Medicaid SP Section 419-B (Reimbursement) Review

The South Carolina Department of Health and Human Services (SCDHHS) will revise and/or reduce reimbursement to providers effective for services provided on or after July 11, 2011 by the amount indicated. Providers incurred a 3% reduction for services provided on or after April 4, 2011. These reductions are in addition to the previous reduction.

Exempt from Reductions

The following are exempt from these reductions:

- J-Codes
- Hospice (except for room and board)
- Federally Qualified Health Center/Rural Health Center (FQHC/RHC) encounter rate
- Program for All-inclusive Care for the Elderly (PACE)
- Inpatient and outpatient hospital services provided by qualifying burn intensive care unit hospitals, critical access hospitals, isolated rural, small rural and certain large rural hospitals as defined by Rural/Urban Commuting Area classes. These large rural hospitals must also be located in a Health Professional Shortage Area (HPSA) for primary care for total population
- Services provided by state agencies
- Catawba tribal members are exempt when services are rendered by the Catawba Service Unit in Rock Hill, South Carolina and when referred to a specialist or other medical provider by the Catawba Service Unit.

SERVICE	4.19-B PAGE/SECTION	COMMENTS
Other Laboratory and X-Ray Services	Page 2/Section 3	Reduce reimbursement by 7%
Private Duty Nursing	Page 2 and 4.19-D, page 30	Reduce reimbursement by 4%.
Children's Personal Care	Page 2.1	Reduce reimbursement by 2%
Medical Professionals		
Podiatrists' Services	Page 3/Section 6.a	Podiatrist reimbursement reduced by 7%
Optometrists' Services (Vision Care Services)	Page 3/Section 6.b	5% for Optometrist to be consistent with Opthalmologists
Chiropractor's Services	Page 3/Section 6.c	Chiropractor reimbursement reduced by 7%
Certified Registered Nurse Anesthetist(CRNA)	Page 3/section 6.d	CRNA reduced 3% reflected from Anesthesiologist rate

Medicaid SP Section 419-B (Reimbursement) Review

Nurse Practitioner Psychologists Licensed Midwives' Services Physical Therapy Occupational Therapy Speech/Language and Audiological Services Nurse Midwife Services	Page 3 Page 3 Page 3 Page 3b/Section 11.a & 11b Page 3b/Section 11.c Page 6.2/Section 17	Nurse Practitioner reduction reflected as a percentage of applicable physician rate Psychologist reimbursement reduced by 7% Licensed Nurse Midwife reduction reflected as a percentage of applicable physician rate All therapy services reduced by 7% All therapy services reduced by 7% Nurse Midwife Services reduction reflected as a percentage of applicable physician rate
Integrated Personal Care	Page 6e of 3.1-A	Reduce reimbursement by 7%.
Home Health Services	Pages 3.1, 3a & 5/Section 12c; Att. 3.1A, page 4B	Reduce reimbursement by 4%. Eliminate medical social work visits.
Clinical Services:	Page 3a/Section 9	Reduce reimbursement by 4%. (Exempt FQHCs and RHCs) *Covers ambulatory surgical centers, end stage renal disease clinics, and county health departments.*
Dental Services	Page 3a/Section 10	Aggregate reduction of 3%.
Prescribed Drugs	Page 3b/Section 12.a	Reduce dispensing fee from $4.05 to $3.00. Reduce reimbursement from AWP minus 13% to 16%.
Prosthetic Devices and Medical Supplies Equipment and Services (DME)	Page 5/Section 12.c	Expenditure reductions through updated state specific fee schedule.
Transportation	Page 6h-6h.4/Section 24a	Reduce reimbursement by 4% for non-broker provided transportation.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF SOUTH CAROLINA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE
(Reference Attachment 3.1-A)

2.a. OUTPATIENT HOSPITAL SERVICES

I. General Provisions

A. Outpatient Hospital Reimbursement and Upper Payment Limit (UPL) Provision

This plan establishes the methods and standards for reimbursement of outpatient hospital services effective October 1, 2013. Under this plan, a retrospective reimbursement system will be available for the following qualifying hospitals:

- Effective for services provided on or after October 1, 2013, SC general acute care hospitals designated as SC critical access hospitals or those identified as SC isolated rural and small rural hospitals as defined by Rural/Urban Commuting Area classes will receive retrospective cost settlements that represent one-hundred percent (100%) of allowable SC Medicaid outpatient costs which includes base, capital and Direct Medical Education (DME) costs. Additionally, certain SC large rural hospitals as defined by Rural/Urban Commuting Area classes and are located in a Health Professional Shortage Area (HPSA) for primary care for total population will receive one-hundred percent (100%) of allowable SC Medicaid outpatient costs which includes base, capital and DME costs.

- Effective for services provided on or after October 1, 2013, SC large rural hospitals as defined by Rural/Urban Commuting Area classes with an average of 35 full time equivalent occupied beds or less based upon hospital fiscal year 2008 thru 2011 cost report census data will receive retrospective cost settlements that represent one-hundred percent (100%) of allowable SC Medicaid outpatient costs which includes base, capital and DME costs.

- Effective for services provided on or after October 1, 2013, the retrospective cost settlement amount for qualifying hospitals with a burn intensive care unit will represent one-hundred percent (100%) of allowable SC Medicaid outpatient costs which includes base, capital, and DME costs. In order for a hospital to qualify under this scenario, a hospital must:

  a. Be located in South Carolina or within 25 miles of the South Carolina border;

  b. Have a current contract with the South Carolina Medicaid Program; and

  c. Have at least 25 beds in its burn intensive care unit.

- For all hospitals eligible to receive its individual hospital specific outpatient multiplier effective for services provided on or after July 1, 2014, the Medicaid Agency will cap the hospital specific outpatient hospital multipliers at the 75th percentile of the October 1, 2013 hospital specific outpatient hospital multipliers of the SC general acute care hospitals, the SC long term acute care hospitals, and the qualifying out of state border general acute care hospitals which receive its own hospital specific outpatient hospital multiplier. The Graduate Medical Education (Direct Medical Education) component of the hospital specific outpatient multipliers will not be impacted by this change. For hospitals whose hospital specific outpatient multiplier falls below the 10th percentile, these hospitals will be reimbursed at the 10th percentile hospital specific outpatient multiplier. However, any teaching hospital whose hospital specific outpatient multiplier falls below the 10th percentile will continue to receive its October 1, 2013 hospital specific outpatient multiplier.

- For all hospitals eligible to receive its individual hospital specific outpatient multiplier effective for services provided on or after October 1, 2015, the Medicaid Agency will cap the hospital specific outpatient hospital multipliers at the 65th percentile of the October 1, 2014 hospital specific outpatient hospital multipliers of the SC general acute care hospitals, the SC long term acute care hospitals, and the qualifying out of state border general acute care hospitals which receive its own hospital specific outpatient hospital multiplier. The Graduate Medical Education (Direct Medical Education) component of the hospital specific outpatient multipliers will not be impacted by this change. For hospitals whose hospital specific outpatient multiplier falls below the 15th percentile, these hospitals will be reimbursed at the 15th percentile hospital specific outpatient multiplier. However, any teaching hospital whose hospital specific outpatient multiplier falls below the 15th percentile will continue to receive its October 1, 2014 hospital specific outpatient multiplier.

  For hospitals that are eligible to receive retrospective cost reimbursement and fall under the 15th percentile, these hospitals will be eligible to receive Medicaid outpatient hospital reimbursement in excess of cost subject to aggregate upper payment limitations. Conversely, hospitals that are eligible to receive retrospective cost settlement and are capped by the 65th percentile methodology will be reimbursed the lower of allowable actual Medicaid reimbursable outpatient hospital costs or Medicaid outpatient hospital payments at the 65th percentile for services provided on or after October 1, 2015.

- Effective for outpatient hospital services provided on or after October 1, 2014, the South Carolina Department of Health and Human Services has updated its current designation of South Carolina (SC) defined rural hospitals with the following SC defined rural hospital criteria:

  SC defined rural hospitals will include all SC Critical Access Hospitals (CAH); all SC hospitals located in the state's Zip Code Tabulation Areas (ZCTAs) classified as Moderately Rural/Rural; all SC hospitals located in Primary Care Health Professional Shortage Areas (HPSAs) for Total Population; SC hospitals located in Persistent Poverty Counties with ≤130 Licensed Beds; and SC hospitals located in Equally Rural/Urban ZCTAs with ≤90 Licensed Beds. ZCTAs are classed as Rural or Urban based on their population designations as defined by the 2010 Census. Each rural/urban classification reflects the relative proportion of ZCTA residents living in rural versus urban areas. These classifications are as follows.

  - Urban: 80.0% to 100.0% Urban
  - Moderately Urban: 60.0% to 79.9% Urban
  - Equally Rural/Urban: 40.1% to 59.9% Rural/Urban
  - Moderately Rural: 60.0% to 79.9% Rural
  - Rural: 80.0% to 100.0% Rural

  The percentage of the population that is not Urban is considered Rural by the US Census.

  Effective October 1, 2016, an additional SC defined rural hospital criterion was created to include a SC hospital that is located within a "persistent poverty county" as defined in Public Law (P.L.) 112-74 that is not otherwise eligible for higher reimbursement.

Determination of the Statewide Outpatient Hospital Fee Schedule Rates:

The October 1, 2007 statewide outpatient hospital fee schedule rates for acute care and long term acute care hospitals will be based upon the allowable outpatient cost information of covered services from each acute care hospital's FY 2005 cost report. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of outpatient hospital services. The agency's fee schedule rate was set as of October 1, 2007 and is effective for services provided on or after that date. All rates are published on the agency's website at https://www.scdhhs.gov/provider-type/hospital-services-provider-manual-040105-edition-posted-032205. All contracting SC acute care hospitals as well as out of state contracting border hospitals with SC Medicaid fee for service inpatient claims utilization of at least 200 claims were used in this analysis. The source document for Medicaid allowable outpatient costs will be the CMS-2552, which is the Medicare/Medicaid cost report. Allowable Medicaid outpatient costs will be determined in accordance with the Provider Reimbursement Manual Publication 15. However, for clarification purposes, one hundred percent (100%) of the South Carolina general acute care hospital provider tax will be considered an allowable Medicaid cost. Outpatient allowable costs, charges and statistics will be extracted from the cost report and prepared for the rate computations using the following general guidelines. The FY 2005 SCDHHS Management and Administration Reporting System (MARS) paid claims summary data report for each acute care hospital identified above will also be used during the analysis.

- As filed total facility costs are identified from each facility's FY 2005 Worksheet B Part I (BI) CMS-2552 cost report. Total outpatient facility costs would include operating, capital, and direct medical education. CRNA costs identified under BI, column 20 are removed from allowable costs. Observation cost is reclassified.

- As filed total facility costs will be allocated to Medicaid outpatient hospital cost using the following method:

  A cost-to-charge ratio for each ancillary service will be computed by dividing total costs as adjusted in this section by total charges as reported on Worksheet C. This cost-to-charge ratio will then be multiplied by SC Medicaid covered charges (as reported on Worksheet D Part V for Medicaid outpatient ancillary charges) to yield total SC Medicaid outpatient ancillary costs. The SC Medicaid outpatient cost-to-charge ratio will be determined by taking the sum of the SC Medicaid outpatient ancillary costs and dividing this amount by the sum of the SC Medicaid outpatient covered ancillary charges. The SC Medicaid outpatient cost-to-charge ratio will then be multiplied by the facility's SC Medicaid covered outpatient charges as identified on the SCDHHS MARS summary paid claims data report to determine each hospital's allowable SC Medicaid outpatient cost for FY 2005.

- The allowable Medicaid outpatient costs are summed to determine the aggregate Medicaid outpatient costs for FY 2005. An aggregate Medicaid allowable cost target was established at 95% of allowable Medicaid outpatient costs.

- After establishing the FY 2005 aggregate Medicaid allowable cost target, several actuarial models were developed and FY 2005 outpatient claims were repriced to determine the uniform increase in the statewide outpatient fee schedule rates. In order to trend the rates to the period October 1, 2007 through September 30, 2008, a 3.5% annual trend factor was applied. As a result of these steps, the statewide outpatient fee schedule rates increased by 135% effective October 1, 2007.

Determination of Hospital Specific Outpatient Multipliers:

In order to convert the statewide outpatient fee schedule rate payment into a hospital specific payment, an outpatient multiplier will be developed for each hospital. The outpatient multiplier will adjust the calculated statewide outpatient fee schedule claims payment to a hospital specific payment and will represent the projected outpatient costs calculated in accordance with Agency defined criteria effective

November 1, 2012 and incorporate the impact of the July 11, 2011 payment reductions for the classes of hospitals outlined in this and the following three paragraphs. Hospitals that receive a hospital specific outpatient multiplier will be those eligible to receive retrospective cost settlements and those SC general acute care hospitals that no longer are eligible to receive retrospective cost settlements effective for services provided on or after November 1, 2012 as well as qualifying out of state border hospitals that have S C Medicaid fee for service inpatient claims utilization of at least 200 claims.

Effective for services provided on or after November 1, 2012, all SC general acute care hospitals except those designated as SC critical access hospitals, SC isolated rural and small rural hospitals, certain SC large rural hospitals located in a Health Professional Shortage Area (HPSA) for primary care for total population, SC large rural hospitals as defined by Rural/Urban Commuting Area classes with an average of 35 full time equivalent occupied beds or less based upon hospital fiscal year 2008 thru 2011 cost report census data and qualifying burn intensive care unit hospitals which contract with the SC Medicaid Program will have its November 1, 2012 hospital specific outpatient multiplier calculated to reflect the impact of the July 11, 2011 payment reductions (i.e. 93% of allowable Medicaid targeted base costs less Direct Medical Education (DME)). Additionally, the hospital specific multipliers of the SC general acute care hospitals identified above with interns/residents and allied health alliance training programs will be further adjusted to account for the allowance of eighty-seven.three percent (87.3%) of allowable SC Medicaid outpatient hospital DME costs (including the DME capital related costs).Effective for services occurring on or after October 1, 2013, the base portion of the November 1, 2012 hospital specific outpatient multiplier was increased by 2.75% for all SC general acute care hospitals. However, for SC general acute care teaching hospitals as defined in Attachment 4.19-A, the DME portion of the November 1, 2012 hospital specific outpatient multipliers was not subject to the 2.75% increase. Effective for services provided on or after October 1, 2014, the base portion of the September 30, 2014 hospital specific outpatient multipliers for all SC general acute care hospitals were increased by 2.50%. However, for SC general acute care hospitals as defined in Attachment 4.19-A, the DME portion of the hospital specific outpatient multiplier was not subject to the 2.50% increase.

Effective for services provided on or after November 1, 2012, qualifying out of state border hospitals that have SC Medicaid fee for service claim utilization of at least 200 claims will have its November 1, 2012 hospital specific outpatient multiplier calculated to reflect the impact of the July 11, 2011 payment reductions (i.e. 93% of allowable Medicaid targeted base costs less DME). Additionally, the hospital specific outpatient multipliers of the out of state border hospitals identified above with interns/residents and allied health alliance training programs will be further adjusted to account for DME costs (including the capital related costs) no longer being reimbursed to qualifying out of state border hospitals. Effective for services occurring on or after October 1, 2013, the base portion of the November 1, 2012 hospital specific outpatient multiplier was increased by 2.75% for qualifying out of state border general acute care hospitals. Effective for services provided on or after October 1, 2014, the base portion of the September 30, 2014 hospital specific outpatient multipliers

for qualifying out of state border general acute care hospitals was increased by 2.50%. However, for SC general acute care hospitals as defined in Attachment 4.19-A, the DME portion of the hospital specific outpatient multiplier was not subject to the 2.50% increase. DME costs continue to be non-reimbursable for out of state border general acute care teaching hospitals.

Effective for services provided on or after November 1, 2012, all SC general acute care hospitals designated as SC critical access hospitals, SC isolated rural and small rural hospitals, certain SC large rural hospitals located in a Health Professional Shortage Area (HPSA) for primary care for total population, SC large rural hospitals as defined by Rural/Urban Commuting Area classes with an average of 35 full time equivalent occupied beds or less based upon hospital fiscal year 2008 thru 2011 cost report census data and qualifying burn intensive care unit hospitals which contract with the SC Medicaid Program will have its November 1, 2012 hospital specific outpatient multiplier calculated to reflect the impact of the July 11, 2011 payment reductions (i.e. 97% of allowable Medicaid targeted costs including DME). Effective for services occurring on or after October 1, 2013, the November 1, 2012 hospital specific outpatient multiplier was increased by 2.75% for all SC defined rural hospitals and burn intensive care unit hospitals which qualify for retrospective cost settlement.

For all hospitals eligible to receive a hospital specific outpatient multiplier effective for services provided on or after July 1, 2014, the Medicaid Agency will cap the hospital specific outpatient hospital multipliers at the 75th percentile of the October 1, 2013 hospital specific outpatient hospital multipliers of the SC general acute care hospitals, the SC long term acute care hospitals, and the qualifying out of state border general acute care hospitals which receive its own hospital specific outpatient hospital multiplier. The Graduate Medical Education (Direct Medical Education) component of the hospital specific outpatient multipliers will not be impacted by this change. For hospitals whose hospital specific outpatient multiplier falls below the 10th percentile, these hospitals will be reimbursed at the 10th percentile hospital specific outpatient multiplier. However, any teaching hospital whose hospital specific outpatient multiplier falls below the 10th percentile will continue to receive its October 1, 2013 hospital specific outpatient multiplier.

For all hospitals eligible to receive its individual hospital specific outpatient multiplier effective for services provided on or after October 1, 2015, the Medicaid Agency will cap the hospital specific outpatient hospital multipliers at the 65th percentile of the October 1, 2014 hospital specific outpatient hospital multipliers of the SC general acute care hospitals, the SC long term acute care hospitals, and the qualifying out of state border general acute care hospitals which receive its own hospital specific outpatient hospital multiplier. The Graduate Medical Education (Direct Medical Education) component of the hospital specific outpatient multipliers will not be impacted by this change. For hospitals whose hospital specific outpatient multiplier falls below the 15th percentile, these hospitals will be reimbursed at the 15th percentile hospital specific outpatient multiplier. However, any teaching hospital whose hospital specific outpatient multiplier falls below the 15th percentile will continue to receive its October 1, 2014 hospital specific outpatient multiplier.

Effective for outpatient hospital services provided on or after October 1, 2014, the South Carolina Department of Health and Human Services has updated its current designation of South Carolina (SC) defined rural hospitals with the following SC defined rural hospital criteria:
SC defined rural hospitals will include all SC Critical Access Hospitals (CAH); all SC hospitals located in the state's Zip Code Tabulation Areas (ZCTAs) classified as Moderately Rural/Rural; all SC hospitals located in Primary Care Health Professional Shortage Areas (HPSAs) for Total Population; SC hospitals located in Persistent Poverty Counties with ≤130 Licensed Beds; and SC hospitals located in Equally Rural/Urban ZCTAs with ≤90 Licensed Beds. ZCTAs are classed as Rural or Urban based on their population designations as defined by the 2010 Census. Each rural/urban classification reflects the relative proportion of ZCTA residents living in rural versus urban areas. These classifications are as follows:

- Urban: 80.0% to 100.0% Urban
- Moderately Urban: 60.0% TO 79.9% Urban
- Equally Rural/Urban: 40.1% to 59.9% Rural/Urban
- Moderately Rural: 60.0% to 79.9% Rural
- Rural: 80.0% to 100.0% Rural

The percentage of the population that is not Urban is considered Rural by the US Census.

Effective October 1, 2016, an additional SC defined rural hospital criterion was created to include a SC hospital that is located within a "persistent poverty county" as defined in P.L. 112-74 that is not otherwise eligible for higher reimbursement.

Therefore, effective for services provided on or after October 1, 2014, the base portion of the September 30, 2014 hospital specific outpatient multiplier for all SC general acute care hospitals that qualify as rural as well as qualifying burn intensive care unit hospitals was increased by 2.50%. However, for SC general acute care teaching hospitals as defined in Attachment 4.19-A, the DME portion of the hospital specific outpatient multiplier was not subject to the 2.50% increase.

Hospital Specific Outpatient Multiplier Calculation Effective On and After November 1, 2012

The following methodology is employed in the computation of the hospital specific outpatient multiplier effective November 1, 2012:

a) The hospital specific outpatient multipliers will continue to be calculated so that outpatient hospital reimbursement approximates the Department's specified percent of allowable Medicaid costs for each eligible hospital as described under the section titled "Determination of Hospital Specific Outpatient Multipliers".

b) A cost to charge ratio will be calculated for Medicaid outpatient hospital services. This ratio will be calculated using cost from worksheet B Part 1 Column 24, charges from worksheet C Column 8, and Medicaid cost settled ancillary charges obtained from the Medicaid Management and Administration Reporting System (MARS) identified on worksheet D part V column 3. The Medicaid outpatient hospital cost-to-charge ratio will be determined by taking the sum of the SC Medicaid outpatient ancillary costs and dividing this amount by the sum of the SC Medicaid covered outpatient ancillary charges. Charges not covered by the hospital payment system, such as CRNA and ambulance, must be excluded from this calculation. Effective for services provided on or after July 11, 2011, two cost to charge ratios will be determined for teaching hospitals. The first cost to charge ratio will be determined on base and all capital related costs except those associated with DME capital costs using the methodology previously described. The second cost to charge ratio will be determined using DME costs only (including the capital portion of DME Costs) using the methodology previously described. The applicable reductions (i.e. 93% or 97% to base and capital and 100% or 87.3% to DME) will be applied to the calculated cost for each cost pool and an adjusted cost/charge ratio will be determined.

c) Next, each hospital's cost to charge ratio will be further adjusted upward or downward for the effect of the Hospital Fiscal Year (HFY) 2010 audit adjustment factor. The HFY 2010 audit adjustment factor is determined by dividing the audited HFY 2010 Medicaid outpatient cost to charge ratio by the interim adjusted HFY 2010 Medicaid outpatient hospital cost to charge ratio.

d) The adjusted hospital fiscal year 2011 Medicaid outpatient hospital cost to charge ratio for each hospital, as described above in b) and c), is multiplied by each hospital's Medicaid outpatient hospital allowed charges based upon services provided during the period October 1, 2011 through June 30, 2012.

e) The Medicaid allowable outpatient cost determined in d) above is reduced by one and a half percent (1.5%) to determine the cost target to be used for each eligible hospital to receive a hospital specific outpatient multiplier. The one and a half percent reduction is applied to take into account the difference between the cost report year and the claims data period.

f) The Medicaid cost target for each hospital determined in e) above will then be compared to each hospital's corresponding base Medicaid fee for service claims payments (including co-pay and TPL) prior to the application of the hospital specific outpatient multiplier in effect during the payment period outlined in d) above to determine the hospital specific outpatient multiplier effective November 1, 2012. To determine the base Medicaid fee for service claims payments for services provided on and after October 1, 2011 during the October 1, 2011 through June 30, 2012 claims payment period prior to the application for the hospital specific outpatient multiplier, the claim payments for this period are divided by the October 1, 2011 hospital specific outpatient multiplier. A further adjustment to base Medicaid fee for service claims revenue was made for a 75% reduction in OP therapy rates.

g) Effective for services occurring on or after October 1, 2013, the November 1, 2012 hospital specific outpatient multiplier was increased by 2.75% for all SC general acute care non-teaching hospitals and qualifying out of state border general acute care teaching and non-teaching hospitals. Effective for services occurring on or after October 1, 2013, the November 1, 2012 hospital specific outpatient multiplier for all SC teaching hospitals as defined by Attachment 4.19-A was increased by the proportion of Medicaid outpatient DME costs to total Medicaid outpatient costs (including DME) multiplied by 2.75%. For all hospitals eligible to receive its individual hospital specific outpatient multiplier effective for services provided on or after July 1, 2014, the Medicaid Agency will cap the hospital specific outpatient hospital multipliers at the 75th percentile of the October 1, 2013 hospital specific outpatient hospital multipliers of the SC general acute care hospitals, the SC long term acute care hospitals, and the qualifying out of state border general acute care hospitals which receive its own hospital specific outpatient hospital multiplier. The Graduate Medical Education (Direct Medical Education) component of the hospital specific outpatient multipliers will not be impacted by this change. For hospitals whose hospital specific outpatient multiplier falls below the 10th percentile, these hospitals will be reimbursed at the 10th percentile hospital specific outpatient multiplier. However, any teaching hospital whose hospital specific

outpatient multiplier falls below the 10th percentile will continue to receive its October 1, 2013 hospital specific outpatient multiplier. For all other hospitals that did not receive a hospital specific outpatient multiplier, an outpatient multiplier of .93 will be assigned to those hospitals. The hospital specific outpatient multiplier determined above will be applied after the fee schedule payment has been calculated prior to any reduction for third party liability and coinsurance.

h) Effective for services occurring on or after October 1, 2014, the base portion of the September 30, 2014 hospital specific outpatient multipliers was increased by 2.50% for all SC general acute care non-teaching hospitals and qualifying out of state border general acute care teaching and non-teaching hospitals. Effective for services occurring on or after October 1, 2014, the base portion of the September 30, 2014 hospital specific outpatient multiplier for all SC teaching hospitals as defined by Attachment 4.19-A was increased by the proportion of total outpatient DME costs to total outpatient costs (including DME) multiplied by 2.50%. For all hospitals eligible to receive its individual hospital specific outpatient multiplier effective for services provided on or after July 1, 2014, the Medicaid Agency will cap the hospital specific outpatient hospital multipliers at the 75th percentile of the October 1, 2013 hospital specific outpatient hospital multipliers of the SC general acute care hospitals, the SC long term acute care hospitals, and the qualifying out of state border general acute care hospital which receive its own hospital specific outpatient hospital multiplier. The Graduate Medical Education (Direct Medical Education) component of the hospital specific outpatient multipliers will not be impacted by this change. For hospitals whose hospital specific outpatient multiplier falls below the 10th percentile, these hospitals will be reimbursed at the 10th percentile hospital specific outpatient multiplier. However, any teaching hospital whose hospital specific outpatient multiplier falls below the 10th percentile will continue to receive its October 1, 2013 hospital specific outpatient multiplier. For all other hospitals that did not receive a hospital specific outpatient multiplier, an outpatient multiplier of .93 will be assigned to those hospitals. The hospital specific outpatient multiplier determined above will be applied after the fee schedule payment has been calculated prior to any reduction for third party liability and coinsurance.

i. For all hospitals eligible to receive its individual hospital specific outpatient multiplier effective for services provided on or after October 1, 2015, the Medicaid Agency will cap the hospital specific outpatient hospital multipliers at the 65th percentile of the October 1, 2014 hospital specific outpatient hospital multipliers of the SC general acute care hospitals, the SC long term acute care hospitals, and the qualifying out of state border general acute care hospitals which receive its own hospital specific outpatient hospital multiplier. The Graduate Medical Education

(Direct Medical Education) component of the hospital specific outpatient multipliers will not be impacted by this change. For hospitals whose hospital specific outpatient multiplier falls below the 15th percentile, these hospitals will be reimbursed at the 15th percentile hospital specific outpatient multiplier. However, any teaching hospital whose hospital specific outpatient multiplier falls below the 15th percentile will continue to receive its October 1, 2014 hospital specific outpatient multiplier. For all other hospitals that did not receive a hospital specific outpatient multiplier, an outpatient multiplier of .93 will be assigned to those hospitals. The hospital specific outpatient multiplier determined above will be applied after the fee schedule payment has been calculated prior to any reduction for third party liability and coinsurance.

Clinical Lab Fee Schedule:

Effective October 1, 2010, all outpatient hospital clinical lab services provided by governmental and private hospitals will be reimbursed at one hundred percent (100%) of the 2010 Medicare Clinical Lab Fee Schedule rates for the State of South Carolina. Effective for services provided on or after October 1, 2011, all outpatient hospital clinical lab services except for those provided by hospitals identified as SC critical access hospitals, SC isolated rural and small rural hospitals, certain SC large rural hospitals located in a Health Professional Shortage Area (HPSA) for primary care for total population, SC large rural hospitals as defined by Rural/Urban Commuting Area classes with an average of 35 full time equivalent occupied beds or less based upon hospital fiscal year 2008 thru 2011 cost report census data or qualifying burn intensive care unit hospitals will be reimbursed at ninety percent (90%) of the 2010 Medicare Clinical Lab Fee Schedule rates for the state of South Carolina. SC critical access hospitals, SC isolated rural and small rural hospitals, certain SC large rural hospitals located in a Health Professional Shortage Area (HPSA) for primary care for total population, SC large rural hospitals as defined by Rural/Urban Commuting Area classes with an average of 35 full time equivalent occupied beds or less based upon hospital fiscal year 2008 thru 2011 cost report census data and qualifying burn intensive care unit hospitals will be reimbursed at ninety-seven percent (97%) of the 2010 Medicare Clinical Lab Fee Schedule rates for the State of South Carolina. Therefore, the hospital specific outpatient multiplier described above will no longer be applied in the determination of outpatient hospital clinical lab services reimbursement.

Retrospective Hospital Cost Settlement Methodology:

Effective October 1, 2013, the following methodology describes the outpatient hospital retrospective cost settlement process for qualifying hospitals. The source document for Medicaid allowable outpatient costs will be the CMS-2552, which is the Medicare/Medicaid cost report. Allowable Medicaid outpatient costs will be determined in accordance with the Provider Reimbursement Manual Publication 15. However, for clarification purposes, one hundred percent (100%) of the South Carolina General acute care hospital provider tax will be considered an allowable Medicaid costs. Effective October 1, 2010, outpatient hospital clinical lab services will no longer be retrospectively cost settled.

- A cost to charge ratio will be calculated for Medicaid outpatient claims. This ratio will be calculated using cost from worksheet B part I, charges from worksheet C, and Medicaid settlement data from worksheet D part V. For ancillary cost centers, a cost-to-charge ratio will be calculated by dividing cost as reported on worksheet B part I by total charges from worksheet C. Medicaid cost for each ancillary cost center will be determined by multiplying this ratio by Medicaid charges as reported on worksheet D part V. Charges not covered by the hospital payment system, such as CRNA and ambulance, must be excluded from this calculation.

- Total allowable Medicaid cost will be determined at the time of cost settlement by multiplying the adjusted cost to charge ratio as calculated above, by Medicaid charges.

- The interim retrospective cost settlement amount will be determined by subtracting payments received from the allowable cost determined above. The payment amount includes Mars report payments and non Mars Report adjustments that were processed during the cost reporting/settlement period. Examples of these adjustments are interim cost settlement payments, etc.

- Effective for services provided on or after July 1, 2014, hospitals that are eligible to receive retrospective cost reimbursement and fall under the 10th percentile will be eligible to receive Medicaid outpatient reimbursement in excess of cost subject to aggregate upper payment limitations. Conversely, hospitals that are eligible to receive retrospective cost reimbursement and are limited by the 75th percentile cap will be reimbursed the lower of allowable actual Medicaid reimbursable outpatient hospital costs or Medicaid outpatient hospital payments at the 75th percentile of the base rate component for services provided on or after July 1, 2014.

- Effective for services provided on or after October 1, 2015, hospitals that are eligible to receive retrospective cost reimbursement and fall under the 15th percentile will be eligible to receive Medicaid outpatient reimbursement in excess of cost subject to aggregate upper payment limitations. Conversely, hospitals that are eligible to receive retrospective cost reimbursement and are limited by the 65th percentile cap will be reimbursed the lower of allowable actual Medicaid reimbursable outpatient hospital costs or Medicaid outpatient hospital payments at the 65th percentile of the base rate component for services provided on or after October 1, 2015.

- Effective for outpatient hospital services provided on or after October 1, 2016, qualifying hospitals eligible to receive retrospective cost settlements (i.e. SC defined rural hospitals and qualifying burn intensive care unit hospitals) will receive tiered Medicaid reimbursement as follows:

  a) Hospitals designated as SC defined rural hospitals or qualifying burn intensive care unit hospitals prior to October 1, 2014 will receive 100% of their SC Medicaid allowable outpatient reimbursable costs subject to the July 1, 2014 and October 1, 2015 normalization actions;

  b) SC hospitals designated as rural hospitals or as qualifying burn intensive care unit hospitals by the SC Medicaid Program for the first time effective on and after October 1 ,2014 will receive the greater of actual Medicaid reimbursement or 90% of their SC Medicaid allowable outpatient reimbursable costs but not to exceed 100% of their SC Medicaid allowable outpatient reimbursable costs;

  c) SC hospitals designated as rural or as a qualifying burn intensive care unit hospital by the SC Medicaid Program for the first time effective on and after October 1, 2016 will receive the greater of actual Medicaid reimbursement or 80% of their SC Medicaid allowable outpatient reimbursable costs but not to exceed 100% of their SC Medicaid allowable outpatient reimbursable costs.

- Effective for discharges incurred on and after January 1, 2020, all SC defined rural hospitals will receive retrospective cost settlements equaling 100% of their SC Medicaid outpatient hospital reimbursable cost subject to the July 1, 2014 and October 1, 2015 normalization actions.

For clarification purposes, all interim retrospective cost settlements will be subject to final audit. Any underpayment/(overpayment) identified as a result of the final audit will be paid or recouped accordingly.

II. Upper Payment Limits:

Outpatient hospital reimbursement shall be made in accordance with the upper payment limit requirements defined in 42 CFR 447.321.

Non-State Owned Governmental and Private Outpatient Hospital Service Providers

The following methodology is used to estimate the upper payment limit applicable to non-state owned governmental and privately owned or operated outpatient hospitals (i.e. for profit and non-governmental nonprofit facilities). State owned psychiatric hospitals do not provide outpatient hospital services so no UPL demonstration is warranted for this class:

The most recent HFY 2552-10 cost report serves as the base year cost report to be used for Medicaid UPL calculations. In order to determine the Medicare allowable cost using Medicare allowable cost principles (i.e. upper payment limit), the SCDHHS employs the following process:

(1) Medicaid covered outpatient hospital ancillary charges are obtained from the Summary MARS outpatient hospital report. Data source – Summary MARS outpatient hospital report.

(2) Medicaid covered outpatient hospital ancillary cost is determined by multiplying covered Medicaid outpatient hospital ancillary charges as identified on worksheet D Part V, column 3, lines 50 thru 117 by the ancillary cost to charge ratios as reflected on worksheet C, column 8, lines 50 thru 117. Data source – HFY 2552-10 cost report.

(3) The total Medicaid outpatient hospital cost determined in step (2) is then trended using the mid-year to mid-year inflation method and the use of the Second Quarter 2019 Global Insight Indexes – 2014 Based CMS hospital PPS Market Basket in order to trend the base year cost (HFY 2018) to the Medicaid rate period October 1, 2019 through September 30, 2020.

(4) Total base year Medicaid outpatient hospital revenue is derived from each hospital's Summary MARS report based upon each hospital's cost reporting period. Data source – Summary MARS outpatient hospital report. Base year revenue will be adjusted accordingly to reflect any rate/payment methodology changes that may have occurred since and during the base year. For hospitals that receive retrospective cost settlements of the estimated revenue for the FFY 2020 payment period will be adjusted accordingly to reflect no more then trended cost as referenced in step (3) subject to the exceptions granted in the July 1, 2014 and October 1, 2015 normalization actions.

(5) The Medicaid UPL compliance check is determined for each class by comparing the aggregate amounts as determined in (3) above to ensure that projected Medicaid outpatient hospital cost is equal to or greater than projected Medicaid outpatient hospital payments in step (4). In the event that aggregate Medicaid outpatient hospital payments exceed aggregate Medicaid outpatient hospital cost, the hospital specific outpatient multiplier for each facility will be established using the Medicaid cost as reflected in step (3).

Cost Report Requirements:

Cost report requirements under the prospective payment system and retrospective reimbursement system will conform to Medicare cost reporting principles and use as their basis the Medicare Cost Report Form - CMS-2552. In addition, providers must comply with Medicaid specific cost report requirements as published by the DHHS.

All cost report financial and statistical information, the medical information contained on claims and information contained on supplemental worksheets such as the DSH survey, are subject to audit by the DHHS or its designee. The audited information will be used for future rate calculations, retrospective cost settlements, disproportionate share program requirements, utilization review contractor requirements and other analyses.

Co-payment Requirements:

Emergency services are not subject to co-payment. The outpatient cost settlement payment calculation will include uncollected Medicaid co-payment amounts in accordance with 42 CFR 447.57.

B. Objectives

Implementation of the reimbursement methodology provided herein has the following objectives:

- To encourage outpatient resources be used when they are appropriate substitute for inpatient hospital services.

- To discourage the inappropriateness of outpatient hospital resources as a substitute for physician office and clinic services.

- To ensure the continued existence and stability of the core providers who serve the Medicaid population.

C. Definitions

The following definitions shall apply for the purpose of reimbursement under this plan.

1. Outpatient - A patient who is receiving professional services at a hospital which does not admit him and which does not provide him room and board and professional services on a continuous 24-hour basis.

2. Outpatient services - Those diagnostic, therapeutic, rehabilitative, or palliative items or services furnished by or under the direction of a physician to an outpatient by an institution licensed and certified as a hospital. This service will include both scheduled services and the provision of service on an emergency basis in an area meeting licensing and certification criteria.

3. Surgical service – Surgical services are defined as the operative procedures set forth in the ICD – 9-CM surgical procedure codes. Emergency and non-emergency surgical services are included as surgical services.

4. Non surgical services – Emergency or non-emergency services rendered by a physician which do not meet the criteria for surgical or treatment/therapy/testing services.

   a. Emergency services – Services rendered to clients who require immediate medical intervention for an condition for which delay in treatment may result in death or serious impairment.

   b. Non-emergency service – Non-emergency services are defined a scheduled or unscheduled visits to an outpatient hospital clinic or emergency room where a professional service is rendered.

5. Treatment/Therapy/Testing service – Such services are defined as laboratory, radiology, dialysis, physical, speech, occupational, psychiatric, and respiratory therapies and testing services.

II. Scope Of Services

Effective with dates of service July 1, 1988, hospitals certified for participation under the Health Insurance for the Aged Program under Title XVIII of the Social Security Act and participating under the Medicaid Program shall be reimbursed for outpatient services rendered

to eligible clients according to one of three types of outpatient services categories. These categories are prioritized as follows:

A. Surgical services

B. Nonsurgical services

C. Treatment/Therapy/Testing services

A. Surgical Services

1. Services Included in Surgery Payment

Surgical services shall include those outpatient services for which a valid ICD-9-CM surgical procedure code is indicated. For the purposes of reimbursement, surgical services shall be all-inclusive of the services rendered, including but not limited to drugs, anesthesia, IV, blood, supplies, nursing services, operating room, recovery room, prosthesis, etc. Effective October 1, 2010, any outpatient hospital clinical lab services performed under this service category will be separately reimbursed outside of the all-inclusive rate. Physician's services and observation room charges are not included and may be billed separately.

2. Payment Method

a. Surgical services shall be compensated based on the lesser of the charge for services or an all-inclusive fee. ICD-9-CM surgical procedures shall be classified by procedures of similar complexity which consume a like amount of resources. An all-inclusive fee shall be established for each class. However, effective October 1, 2010, any outpatient hospital clinical lab services performed under this service category will be separately reimbursed outside of the all-inclusive rate.

b. Fees for surgical classifications are based on a relationship to the average historical payment made by the state of such procedures as determined from claim history data. ICD-9-CM procedure codes which are not classified under the initial grouping of procedures will be assigned a class by DHHS. Professional medical personnel will be responsible for this function. A procedure may be assigned to an existing classification or a new classification may be created to compensate for the procedure at the discretion of DHHS.

c. In the case of multiple surgeries only one payment will be made. The class producing the highest rate of payment will be selected as the payment rate.

B. Non-surgical Services

1. Services Included in Non-surgical Services Payment

Non-surgical services shall include those scheduled and unscheduled emergency or clinic visits to hospitals which do not meet the criteria for surgical services, but which involve a professional service(s) or direct patient contact other than that associated with a treatment/therapy/testing services. For purposes of reimbursement, non-surgical services shall be all-inclusive of the services rendered, including but not limited to drugs, anesthesia, IV, blood, supplies, nursing services, emergency room, clinic, etc. Effective October 1, 2010, any outpatient hospital clinical lab services performed under this service category will be separately reimbursed outside of the all-inclusive rate. Physician services and observation room charges are not included and may be billed separately.

2. Payment Method

a. Non-surgical services shall be compensated based on the lesser of the charge for services or an all-inclusive fee. ICD-9-CM disease classifications shall be grouped by procedures of similar complexity which consume a like amount of resources. An all inclusive fee shall be established for each class. However, effective October 1, 2010, any outpatient hospital clinical lab services performed under this service category will be separately reimbursed outside of the all-inclusive rate.

b. Fees for non-surgical classifications are based on a relationship to the average historical payment made by the state of such procedures as determined from claim history data. ICD-9-CM diagnostic procedure codes which are not classified under the initial grouping of procedures will be assigned a class by the Commission. Professional medical personnel will be responsible for this function.

A procedure may be assigned to an existing classification or a new classification may be created to compensate for the procedure at the discretion of DHHS.

c. In the case of multiple diagnosis only one payment will be made. The class producing the highest rate of payment will be selected as the payment rate.

C. Treatment/Therapy/Testing Services

The methods and standards for payment of treatment/testing/therapy services are divided into two categories:

- Laboratory and Radiology
- Other Treatment, Therapy and Testing Services

1. Laboratory and Radiology

a. Services Included in Payment Amount

Payment for laboratory and radiology services rendered to outpatients shall consist of a fee for services. Effective October 1, 2010, all outpatient hospital clinical lab services will be reimbursed at one hundred percent (100%) of the 2010 Medicare Clinical Lab Fee Schedule rates for the State of South Carolina. Effective for services provided on or after October 1, 2011, all outpatient hospital clinical lab services except for those provided by hospitals identified as SC critical access hospitals, SC isolated rural and small rural hospitals, certain SC large rural hospitals located in a Health Professional Shortage Area (HPSA) for primary care for total population, SC large rural hospitals as defined by Rural/Urban Commuting Area classes with total licensed beds of 90 or less or qualifying burn intensive care unit hospitals will be reimbursed at ninety percent (90%) of the 2010 Medicare Clinical Lab Fee Schedule rates for the state of South Carolina. SC critical access hospitals, SC isolated rural and small rural hospitals, certain SC large rural hospitals located in a Health Professional Shortage Area (HPSA) for primary care for total population, SC large rural hospitals as defined by Rural/Urban Commuting Area classes with total licensed beds of 90 or less and qualifying burn intensive care unit hospitals will be reimbursed at ninety-seven percent (97%) of the 2010 Medicare Clinical Lab Fee Schedule rates for the State of South Carolina, The fee excludes payment for services rendered directly to a patient by a physician (professional).

b. Payment Method

i. Payments for technical radiology and laboratory services shall be made based on the lesser of the charge or fixed fee for each CPT coded procedure.

2. Other Treatment, Therapy and Testing Services

a. Services Included In Payment Amount

Treatment, therapy, and testing services under this part include dialysis treatment, respiratory, physical, speech, occupational, audiological therapies, psychiatric treatment and testing. The payment for each treatment and testing category is a payment per service. Therapy services rendered under this part include the professional services component. If such services are provided in conjunction with surgical or non-surgical services, no separate payment shall be made.

b. Payment Method

Services under this part shall be reimbursed the lesser of the charge for the service or the fixed fee. A fixed fee is assigned for each service type under this part.

III. Utilization Review

1. DHHS shall review the medical necessity of all services rendered under this part. Such review may occur on a pre-or post-payment basis or, at the options of DHHS may occur prior to the rendering of the service. Where such services are determined not medially necessary, payment shall be recovered using the most expedient means, or denied in its entirely.

2. DHHS shall also review the appropriateness of billing for all service types. Such review may occur pre- or post-payment and may produce payment denial or recovery by the most expedient means possible.

IV. Payments to Out-of-State Providers:

Payments to out-of-state providers shall be made based on the lesser of the fixed fee specified for the service or the charge for the service in the case of surgery, nonsurgery or treatment, therapy and testing services.

2b. Rural Health Clinics:

Effective January 1, 2001, in accordance with the requirements of BIPA 2000, an alternative payment methodology will be used for reimbursement of Rural Health Clinics (RHCs). The alternative payment methodology is described below. It has been determined by a comparison of rates using the prospective payment methodology (PPS) and the alternative payment methodology that the alternative methodology as described will provide reimbursement to RHCs which is at least equal to the amount that would be received using the PPS methodology. The FY 01 PPS baseline rates were determined by weighing the RHC specific rates for FYs 1999 and 2000 using Medicare cost principles, by the number of Medicaid encounters provided each year.

Under the alternative payment methodology, reimbursement for medically necessary services will be made at 100% of the all-inclusive rate per encounter as established by the Medicare Intermediary. The Medicare rates shall be obtained from the Medicare Intermediary at the end of the RHC's fiscal reporting period to enable SCDHHS to determine the reimbursement due for the period. Provider-based RHCs with less than fifty (50) beds will receive reimbursement at 100% of Medicare reasonable costs not subject to the RHC rate cap. For provider-based RHCs, actual cost and utilization information based on the RHC's fiscal year shall be obtained from the HCFA-2552-96 actual cost report.

Supplies and injections are not billable services and thus are included in the all-inclusive rate. While family planning contraceptives, the technical component of x-rays and EKGs, diagnostic laboratory services, and the application of fluoride varnish are not considered part of the all-inclusive rate, the services can be billed and reimbursed separately under the appropriate Medicaid fee schedules.

At year-end settlement under the alternative payment methodology, comparisons will be made to assure that the final rate paid based on the RHC's fiscal year will provide reimbursement at least equal to the amount available under the PPS methodology.

Circumstances requiring special consideration/disposition are discussed below:

1. For RHCs not agreeing to the cost based alternative payment methodology, reimbursement for a provider's fiscal year will be based on the provider's PPS FY 01 baseline rate which will be updated annually for:

1) the Medicare Economic Index (MEI) and 2) any increases or decreases in the scope of services furnished by that provider during that fiscal year.

2. Under the alternative payment methodology, new RHCs will initially be reimbursed at 100% of the all-inclusive encounter rate as determined by the Medicare Regional Intermediary. Reimbursement is subject to annual revision to the actual cost rate as determined by the Medicare Intermediary based on the RHC's fiscal year. In the event that a new RHC wishes to elect the PPS rate, the PPS rate established shall be equal to 100% of the reasonable costs used in calculating the rates of like RHCs in the same or an adjacent area with a similar caseload.

3. For those RHCs participating as a member of a Medicaid managed care entity (MCE), and receiving either cost based or PPS reimbursement, quarterly reconciliation will be completed. Where necessary, supplemental payments will be made to ensure that the RHC does not receive less reimbursement than would be received under the cost based or PPS reimbursement methodologies. A final annual reconciliation of quarterly supplemental payments will be included in the RHC's fiscal year cost settlement and rate determination.

2c. Federally Qualified Health Centers:

Baseline PPS Rate Setting Methodology

For FQHCs not agreeing to the APM PPS payment methodology, reimbursement for a provider's fiscal year will be based on the provider's PPS FY 01 baseline rate which will be updated annually for: 1) the Medicare Economic Index (MEI) and 2) any increases or decreases in the scope of services furnished by that provider during that fiscal year.

Alternative Payment Methodology (APM) PPS Rate Setting Methodology

Effective for services provided on and after July 1, 2016, the Medicaid Agency will provide reimbursement to Federally Qualified Health Centers (FQHCs) using an alternate payment methodology (APM) via a prospective payment system (PPS). FQHCs must agree to the APM in order to receive payment in accordance with the APM PPS rate setting methodology. The APM PPS will provide reimbursement to FQHCs which will be at least equal to the amount that would be received using the Benefits Improvement and Protection Act of 2000 (BIPA 2000) baseline PPS methodology trended by the MEI annually. The Fiscal Year (FY) 2001 baseline PPS rates were determined by weighing the FQHC provider specific rates for provider FYs 1999 and 2000 based on reasonable cost principles, by the number of Medicaid encounters provided in each year. The APM PPS methodology employed by the Medicaid Agency effective for services provided on and after July 1, 2016 is described below.

First, for each South Carolina FQHC not deemed as a low volume FQHC provider, the fiscal year ending 2014 desk audited Medicaid rate is determined in accordance with the APM in effect prior to July 1, 2016. Under the former APM payment methodology, the cost reports, as submitted, are reviewed for accuracy, reasonableness and allowability of costs as defined per 45 CFR section 75 - Uniform Administrative Requirements, Cost Principles, and Audit Requirements as well as 42 CFR section 413 - Principles of Reasonable Cost Reimbursement. While direct costs of providing SC Medicaid covered FQHC services will be recognized at 100%, overhead costs are limited to no more than 30%. Additionally, the following minimum productivity levels were employed in order to determine the FY 2014 FQHC Medicaid payment rates - physicians shall be 4,200 patient visits per year; mid-level practitioners shall be 2,100 patient

visits per year; and OB/GYN physicians shall be 3,360 patient visits per year. Next, in order to trend the FY 2014 APM PPS rates to the prospective payment period beginning July 1, 2016, the Medicaid Agency employed the use of the midpoint to midpoint trending methodology using the IHS Global Insight 2015 Quarter 3 Forecast published December 22, 2015. For out of state border FQHCs that contract with the State Medicaid Agency or for those in-state FQHCs deemed as a low volume FQHC (i.e. provides less than 50 SC Medicaid FFS encounters during its FY 2014 reporting period), their APM PPS rate effective July 1, 2016 will be based upon its rate in effect on June 30, 2016 increased by 5.48% trend. For out of state border FQHCs that contract with the SC Medicaid Agency for the first time on or after July 1, 2016, the SC Medicaid Agency will reimburse the FQHC at the Medicaid rate in effect upon entrance into the SC Medicaid program as determined by its state's Medicaid Agency. Future Medicaid rates will be adjusted accordingly.

For those FQHCs that are not Public Health Service (PHS) grantees but are designated as "look alikes", these entities have the choice of being reimbursed under the APM PPS or baseline PPS methodology as described_under section 2c of Attachment 4.19-B.

Effective for services provided on and after July 1, 2017, the July 1, 2016 APM PPS rates were increased by the calendar year 2017 Medicare Economic Index trend rate of 1.2%.

Scope of Service Changes

The baseline PPS rate or the APM PPS rate will be adjusted to take into account any change (increase or decrease) in the scope of services furnished by the FQHC. A change in the cost of a service is not considered in and of itself a change in the scope of services. A change in scope will be defined as:

- A change in the type, intensity, duration, and/or amount of services or;
- Adding a South Carolina Medicaid service that was not included in the baseline PPS rate or APM PPS rate calculation or;
- Deleting a South Carolina Medicaid service that was included in the baseline PPS rate or APM PPS rate calculation or;
- Incurring a minimum five percent (5%) cost increase in overhead costs or direct medical costs as a result of the acquisition of or implementation of a singular project or equipment purchase that is not covered by any of the other scope of service change criteria.

The FQHC will be responsible for notifying the Division of Ancillary Reimbursements, in writing, of any increases or decreases in the scope of its services. A modified rate will be established based upon the allowable Medicaid reimbursable costs subject to the reasonableness definitions as described earlier and contained in the annual budget information and effective for services provided on and after the implementation of the scope of service change.

Circumstances Requiring Special Consideration/Disposition:

1. Under the APM PPS payment methodology, new FQHCs will initially be reimbursed at 100% of the all-inclusive encounter rate as determined from a review of a budget submitted by the FQHC based upon the APM payment methodology in effect prior to July 1, 2016. Reimbursement will be reconciled to actual cost on an annual basis based on the FQHC's fiscal year for a minimum period of two years before establishing the annual July 1st APM PPS rate. In the event that a new FQHC wishes to elect the PPS rate, the PPS rate established shall be equal to 100% of the reasonable costs used in calculating the rates of like FQHCs in the same or an adjacent area with a similar caseload.

2. For those FQHCs participating as a member of Medicaid Managed Care Organizations (MCOs) and receiving either APM PPS cost based or baseline PPS reimbursement, the Medicaid Agency will ensure that Medicaid MCOs, at a minimum, are reimbursing FQHCs at least 100% of the July 1, 2016 APM PPS rates on a quarterly basis. However supplemental payments will be made to the FQHCs by the Medicaid Agency only under the following conditions:

    - Dental encounters, a service not provided by SC Medicaid MCOs, will be reconciled quarterly to ensure that the FQHC will receive the Medicaid FFS payment rate for the services provided to MCO members. This process will also hold true for Medicaid fee for service (FFS) individuals receiving dental services provided by a FQHC.

    - For provider rate changes that have not been reflected in the calculation of the annual SC Medicaid MCO rates due to: (1) new FQHCs coming into the Medicaid Program under budget rates; (2) any scope of service rate changes to APM PPS rates since their base year FY 2014 cost report;(3) for FQHC providers operating under the baseline PPS rates with scope of service changes not reflected in their current baseline PPS rate and;(4) if a rate adjustment is required for any other reason than described above. In these instances, payment adjustments will be made to include encounters (FFS and MCO) until that point in time in which the revised rate of the impacted FQHC is reflected in the Medicaid MCO rates.

While quarterly WRAP payments will be made subject to the circumstances outlined within each bullet above within thirty days of receipt of the quarterly Medicaid MCO encounter data submitted from the contracting Medicaid MCOs, annual WRAP reconciliations will be performed and adjustments processed (if applicable) within sixty days after the receipt of the annual Medicaid MCO encounter data from the Medicaid MCOs. Medicaid MCOs will be required to submit the quarterly and annual FQHC encounter data within sixty days from the end of the quarter or annual period requested.

2e. Indian Health Service (IHS) Facilities:

Effective July 1, 1999, DHHS will reimburse IHS facilities (638 facilities) at the rate as determined by the Indian Health Service. For Calendar year 1999, the rate is published in the Federal Register/Vol.64, No. 16/Tuesday, January 26, 1999/Notices, page 3955. Subsequent year rates shall be announced in the Federal Register. The rate shall be an all-inclusive encounter rate per visit for the provision of medically necessary out-patient services provided to both Native and non-Native Americans.

3. Other Laboratory and X-Ray Services:

The Physician Services fee schedule rates are effective for services provided on or after the implementation date as outlined in the Physician Services methodology located at Attachment 4.19-B, Page 2a.2 Section 5. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The agency's fee schedule rates were set as of July 11, 2011 and are effective for services provided on or after that date. All rates are published on the agency's website at www.scdhhs.gov.

4.b Early and Periodic Screening, Diagnosis and Treatment Screening Services:

Medical: The SCDHHS adopted the Bright Futures/ American Academy of Pediatrics (AAP) Medical Periodicity Schedule for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Screening Services.

Reimbursement for EPSDT Screening Services is based on the Physician Services fee schedule rates effective for services provided on or after the implementation date as outlined in the Physician Section 5, Attachment 4.19-B, Page 2a.2. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The agency's fee schedule rates were set as of July 11, 2011 and are effective for services provided on or after that date. All rates are published on the agency's website at www.scdhhs.gov.

Dental: The SCDHHS developed the South Carolina Dental Periodicity Schedule for EPSDT Dental Services effective for services provided on April 1, 2018 or after that date. Reimbursement for EPSDT Dental Services are based on the Dental Services fee schedule rates effective for services provided on or after the implementation date as outlined in the Dental Services Section 10 of Attachment 4.19-B. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. Rates for Preventive, Oral Surgery and Ancillary services were updated on July 1, 2017. The rates for all other dental services were set as of July 11, 2011. All rates are published on the agency's website at www.scdhhs.gov.

Additional services: The SCDHHS allows coverage for additional services that are deemed medically necessary by the provider as outlined in the EPSDT Section 4.b, Attachment 3.1-A, Limitation Supplement, Page 2. Reimbursement for additional medically necessary services effective for services provided on April 1, 2018 or after that date are based on the Physician Services fee schedule rates as outlined in the Physician Section 5, Attachment 4.19-B, Page 2a.2. Except as otherwise noted in the plan, state-developed fee schedule rates for Physician services are the same for both governmental and private providers and those rates were set as of July 11, 2011. All rates are published on the agency's website at www.scdhhs.gov.

Immunizations:
Vaccines for Children Program. The appropriate Immunization Administration for Vaccine/Toxoids Current Procedural Terminology code will be reimbursed to Medicaid providers who administer immunizations in conjunction with an EPSDT screening or other billable service, as well as, for "shots only" visits. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The reimbursement for this service can be found at the Physician Services fee schedule effective for services provided on or after the implementation date as outlined in the Physician Services methodology located at Attachment 4.19-B, Page 2a.2 Section 5. The agency's fee schedule rates were set as of July 11, 2011 and are effective for services provided on or after that date. All rates are published on the agency's website at www.scdhhs.gov.

Payments for EPSDT Services that are not otherwise covered:
Services not listed as covered services in the state agency manuals/state plan will be provided if determined to be medically necessary by the appropriate agency staff or consultants. These are services that are not covered by South Carolina Medicaid and are not listed in any fee schedule. Several methodologies are employed to determine the appropriate reimbursement. The sequence that is employed is listed below:

a) If the service has a Medicare established reimbursement or a Resource Based Relative Value Scale (RBRVS) value, the reimbursement is calculated based on the established methodology used in Section 5 (Physician Services) on Page 2a.2.

b) If neither a Medicare rate nor an RBRVS rate exists and the procedure is covered by the State of South Carolina employee Health plan, a percentage of this rate (not to exceed 100%) is used to reimburse for the service.

c) If neither a Medicare rate nor an RBRVS rate exists and the procedure is not covered by the State of South Carolina employee Health plan, we would negotiate a percentage of charges with the provider to cover this procedure.

Early Intervention/Family Training Services and Sign Language Services

Early Intervention services are therapeutic, training, and support services that facilitate the developmental progress of children between the ages of birth to six years old. Early Intervention services include developmental assessments, treatment planning, home visits, and supports to enhance the development of the child and support his or her family in the care of the child. In addition to Sign Language or Oral Interpreter services for children with a developmental delay and/or disability, Family Training is also considered an Early Intervention service. The list of licensed practitioners of the Healing Arts that provides Family Training services are reflected within the provider manual.

Effective for services provided on or after October 1, 2012, state government owned providers of Family Training services and Sign Language services will be reimbursed a prospective payment rate based upon its most recently filed fiscal year (i.e. FY 2010 for the SC Department of Disabilities and Special Needs (SCDDSN) or FY 2011 for the SC School for the Deaf and the Blind (SCSDB)) Medicaid cost report. In order to trend the base year 15 minute unit rate to the payment period beginning October 1, 2012, the midpoint to midpoint methodology was used and applying either the Medicare Economic Index for calendar year 2010 (1.2%) (for SCDDSN) or CY 2011 (1.6%) (for SCSDB). Effective for Early Intervention/Family Training services provided on or after July 1, 2020, the current reimbursement rates are increased by $.22 per 15 minute unit and will be reimbursed as follows:

Private and Governmental Providers – Birth up to Age 3 - $23.74

SC School for Deaf and Blind – Ages 3 through 6 - $27.95

SC Department of Disabilities and Special Needs – Ages 3 through 6 - $25.54

The SCDHHS will also provide a one-time supplemental payment by August 31, 2020 in an amount not to exceed $100,000 to providers of Early Intervention/Family Training Services and Sign Language Services. The distribution of this supplemental payment is based on each provider's share of submitted claims for these services provided between January 1, 2020 and June 30, 2020.

Medicaid reimbursement rates for Family Training services and Sign Language services are established utilizing Medicare reasonable cost principles, as well as criteria outlined under 45 CFR Part 75 and 42 CFR Part 413. Costs reimbursable in the rates for Family Training services and Sign Language Services include but are not limited to:

1. Personnel costs- the salary and fringe benefit costs associated with direct line staff, meeting credentialing requirements, providing the services in the community mental health centers,
2. Clinical supervision- the salary and fringe benefit cost associated with the Clinical supervision of these services,
3. Supplies- material and supply costs that are required for direct services to patients,
4. Training and travel- training and associated travel expenses that directly relate to maintaining certification, qualifications, or licensure required to render contracted mental health services but not to obtain their initial certification,
5. Indirect Costs- as determined by the application of the provider's federally approved indirect cost rate, federally approved indirect cost plan, or step down allocation as applicable.

Annual Certified Public Expenditure (CPE) Reconciliation Process for State Owned governmental providers:

Each State Owned governmental provider rendering Family Training services and Sign Language services will be required to submit a CMS approved annual cost report to establish the costs of their services. Allowable costs will be accumulated by service definition. Costs by service will be accumulated for the total population of users of the service (i.e. regardless of the source of payment). Allowable costs will be classified as follows:

Direct Costs:

1) Personnel costs- Expenditures from the accounting records of the State Agency for the incurred salaries, payroll taxes, and fringe benefits for the employees providing Family Training services and Sign Language services to beneficiaries. For employees who are not assigned to work 100% of their time in Family training services, time sheets will be required to allocate salary, payroll taxes and fringe benefits,

2) Materials, supplies, and non-capital related equipment expenditures required by the practitioners for the provision of service. The following characteristics determine the charging of supplies to a medical service:

    a) Commonly provided in the course of care/treatment by practitioner without additional charge,
    b) Provided as incidental, but integral to the practitioners' services, and
    c) Used by the "hands-on" medical provider,

3) Training and travel expenses that directly relate to maintaining certification, qualifications, or licensure but not to obtain their initial certification, and
4) Any costs not noted above but directly assignable, excluding subcontract arrangements for direct service delivery and costs included in indirect cost determination.

Supervision:
Costs of supervisory staff will be added to the direct costs associated with practitioners of specific services. The allowability of supervisory costs is determined based on time and effort reports which will identify and separate administrative activities of the supervisor versus those activities that are clinical in nature (i.e. participating in assessment and care plan meetings, participation in follow-up and re-evaluation activities). Time and effort reports completed in accordance with criteria as outlined in 45 CFR Part 75 and 42 CFR Part 413 will be used to determine clinical supervision costs.

Indirect Costs:

Allowable indirect costs can be determined in one of two ways:
1. The application of the provider's federally approved indirect cost rate (or federally approved cost allocation plan) or
2. An allocation of administrative/overhead costs as allowed in accordance with 45 CFR Part 75 and 42 CFR Part 413.

The results of total allowable costs divided by total units of service become the average allowable unit rate for CPE reconciliation purposes. The average allowable unit rate will be multiplied by the applicable Medicaid units of service (as determined by the SCDHHS MMIS). This result becomes the annual allowable Medicaid reimbursement for the governmental provider. This amount is compared to Medicaid interim payments (including TPL) and any prior adjustments and/or recoupments for these services.

For state owned governmental providers that use certified public expenditures as the source of state matching funds and the comparison referred to above identifies an overpayment to the provider, SCDHHS will send a letter to the provider requesting the repayment of only federal funds within 30 days. Should the comparison referred to above identify an underpayment to the provider, SCDHHS will make no further payment to the provider.

Home Based Private Duty Nursing Services:

Home Based Private Duty Nursing reimbursement rates are separately established for Registered Nurses (RN) and Licensed Practical Nurses (LPN). Salaries, fringe benefits, limited direct, and indirect costs are considered in the development of the rates. Services are billed in 6-minute increments; therefore, ten (10) units equate to an hour of care. (In the instances of private duty nursing services to Department of Disabilities and Special Needs (DDSN) clients under 21, these services are billed in fifteen (15) minute increments.) Except as otherwise noted in the plan, the state-developed fee schedule rates are the same for both governmental and private providers of home based private duty nursing services. The agency's fee schedule rate was set as of January 1, 2020 and is effective for services provided on or after that date. The hourly rate for RN and LPN nursing services are as follows:

Registered Nurse (RN) - $34.20
Licensed Practical Nurse (LPN) - $26.00

Effective May 1, 2009, an additional classification of home-based private nursing services is reimbursable for services provided to children who are ventilator or respirator dependent, intubated or dependent on parenteral feeding or any combination of the above. This service has been developed to recognize the skill level that nurses caring for these children must have over and above normal home-based services. An hourly rate adjustment of $3.00 is added to the RN or LPN home based rate for services provided to those children who are defined as High Risk/High Tech. Again, services are billed in 6-minute increments; therefore, ten (10) units equate to an hour of care.

Personal Care Services:

The Personal Care service reimbursement rate (currently $17.00/hour was initially established based upon projected service costs of providers. The payment rate is calculated for Personal Care services on an hourly basis. This rate does not cover room and board services provided to Medicaid recipients. Annual cost reports are reviewed on an as needed basis to ensure the appropriateness of the payment rates in accordance with allowable cost definitions as outlined in 45 CFR Part 75 and 42 CFR Part 413. Services are billed in six (6) minutes increments; therefore, ten (10) units equate to an hour of care. (In the instances of personal care services to DDSN clients under 21, these services are billed in fifteen (15) minute increments.) Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Personal Care services.

Applied Behavior Analysis

Effective for services provided on and after July 1, 2019, the Medicaid agency will reimburse both private and governmental providers of applied behavior analysis (ABA) services based upon a state developed fee schedule. The services to be provided under this section can be accessed via the following agency website address: https://msp.scdhhs.gov/autism/site-page/fee-schedule. Except as otherwise noted in the Plan, state-developed fee schedule rates are the same for both governmental and private providers. The agency's fee schedule rate was set as of July 1, 2019. All rates are published on the SCDHHS public website.

Reimbursement for ABA services is authorized for the treatment, family guidance, and periodic assessment of Autism Spectrum Disorder (ASD) pursuant to the provisions expressed in Attachment 3.1-A of this plan.

To determine an hourly rate for the services provided by a Board Certified Behavior Analyst (BCBA) and a Board Certified Assistant Behavior Analyst (BCaBA), the Medicaid Agency uses the midpoint of the comparable South Carolina state government positions and determines the average hourly rate for BCBA/BCaBA staff. After applying the applicable fringe rate and adding estimated operational expenses, the sum is divided by a productivity factor representative of an estimated number of billable hours to determine an hourly billing rate. Hourly rates are then converted to the time units corresponding to approved billing (HCPCS/CPT) codes to determine the reimbursement rate by billing codes.

To determine an hourly rate for the services provided by a Registered Behavior Technician (RBT), the Medicaid Agency uses the midpoint of the comparable South Carolina state government position and other data sources such as RBT wage surveys and interviews of ABA provider practices to determine the average hourly rate for an RBT. After applying the applicable fringe rate and adding estimated operational expenses for an RBT, the sum of each position is divided by a productivity factor representative of an estimated number of billable hours to determine an hourly billing rate. Hourly rates are then converted to the time units corresponding to approved billing (HCPCS/CPT) codes to determine the reimbursement rate by billing codes.

Therapy Services:

Payment Methodologies for Therapy Services:
Therapy services are rendered by both governmental and private providers and are reimbursed on a fee for service basis. Reimbursable EPSDT Children's Rehabilitative therapy services include but are not limited to:

A. Physical Therapy
Occupational Therapy
Speech/Language Pathology
Audiological Services
Psychological Evaluation and Testing

B. Orientation & Mobility Services

A. Effective January 1, 2007, private and governmental providers (e.g. Local Education Agencies) of therapy services will be reimbursed at 100% of the 2006 South Carolina Medicare Physician Fee Schedule. Effective for services on or after October 1, 2008, physical, occupational and speech therapy rates will be established at 95% of the 2008 South Carolina Medicare Physician Fee Schedule.

Calculation of Therapy Rates With No Corresponding Medicare Rate:
Effective January 1, 2007, reimbursement rates for therapy (PT, OT, and ST) and audiological services not priced under Medicare's resource based relative value scale (RBRVS), the State Health Plan, or by private insurers in the market were determined based upon Medicaid claims experience and the 2006 version of RBRVS for South Carolina. When updates are made to these rates in the future, the same methodology described below will be employed using more current claims and charge data as well as a more recent version of the Medicare RBRVS for South Carolina.

Physician and professional claims for service dates during state fiscal year 2006 (paid through September 30, 2006) were re-priced based upon the allowances dictated by the 2006 version of RBRVS for South Carolina. This analysis revealed that, on average, the DHHS fee schedule was reimbursing 43.24% of charges.

The first step in establishing the allowance for the target procedure codes was to calculate the average submitted charge for each procedure code. The average submitted charge for the procedure code was then multiplied times the average percent of charges reimbursed. **Example:** During SFY 2006, the average unit submitted charge for procedure code 92590 was $61.84. This average was then multiplied times the aggregate discount rate for all professional services (.4324) to produce a 2007 allowance of $26.74.

No cost reports are required nor any cost settlements made to the governmental providers of rehabilitative therapy services due to the move to fee schedule payment rates. State developed fee schedule rates are the same for both governmental and private providers and the fee schedule and any annual/periodic adjustments to the fee schedule are published in Medicaid Bulletins.

B. Orientation and Mobility Services are evaluation and treatment services provided to assist blind and visually impaired individuals achieve maximum independence. The fixed 15 minute rate, applied to both evaluation and treatment services as follows:

T1024/000	Orientation and Mobility Assessment
T1024/0TS	Orientation and Mobility Reassessment
T1024/0TM	Orientation and Mobility Services

This rate has been established at sixty percent (60%) of the average of the 2005 Medicare rates for the following three CPT codes:

97533	Sensory Integration
97535	Self Care Management Training
97537	Community/Work Reintegration

These CPT codes were chosen and averaged as the activities performed as a part of Orientation and Mobility Services most closely identify with various components defined in the three CPT codes listed above. The Medicaid rate has been reduced from 100% of the Medicare average rate to acknowledge the differences in the credentials required for providers of Orientation and Mobility Services from those of the Medicare covered CPT codes.

Nursing Services for Children Under 21:

Initial reimbursement to providers of nursing services for children under the age of 21 is made on the basis of an established fee schedule not to exceed the prevailing charges in the locality for comparable services under comparable circumstances. Reimbursement will be provided on a unit of a quarter of an hour basis for skilled nursing services and a per encounter basis for medication administration and other similar procedures. The current reimbursement rates are based on rates or fees reimbursed for similar services.

State and local government providers must submit annual actual cost and service delivery data. Allowable costs will be determined in accordance with Medicare reasonable cost principles and criteria outlined under 45 CFR Part 75 and 42 CFR Part 413. Future reimbursement rates to state and local government providers shall be the lesser of actual allowable documented cost or the established fee.

4.c Family Planning Services and Supplies:

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. Family Planning Services are reimbursed at an established fee schedule based on the methodologies set forth in Attachment 4.19B, Page 2a.2, Section 5 Physician Services and Attachment 4.19B Page 3b Section 12 Prescribed Drugs. The Physician Services fee schedule rates are effective for services provided on or after the implementation date as outlined in the Physician Section 5, Attachment 4.19-B. Medicaid Bulletins informing the providers of the fee schedule rate changes, as well as the fee schedule itself, are available on the agency's website at http://www.scdhhs.gov/ServiceProviders/FeeSchedules.asp.

5. Physician Services:

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of physician services (including pediatric sub-specialists). The agency's fee schedule rates were set as of July 1, 2019, and are effective for services provided on or after that date. Medicaid Bulletins informing the providers of the fee schedule rate changes, as well as the fee schedule itself, are available on the agency's web site at http://www.scdhhs.gov/ServiceProviders/FeeSchedules.asp.

Payments to physicians are based on the 2019 Medicare fee schedule, as follows:

- The Medicaid fee schedule rates are set at 78% of the Medicare fee schedule for evaluation, preventative care and diagnostic services, and at 71% of the Medicare fee schedule for all other services.

Primary care Providers (PCPs) are reimbursed at 129% of the Medicaid Physician fee schedule. PCPs included physicians enrolled as Family Practice, General Practice, Gynecology, Internal Medicine, Obstetrics, Obstetrics & Gynecology, Pediatrics, Psychiatry, and Child Psychiatry providers.

Payment for vaginal deliveries is $1,100. C-section deliveries are paid $1000.

For those procedures that are not covered by Medicare, reimbursement is determined based on the following:

First, we look at the rate paid by the South Carolina State Health Plan. SCDHHS obtains the State Health Plan fee schedule from the SC Public Benefit Authority (SCPEBA), the state agency responsible for administering benefits for state employees. If there is a rate for the service (code) on SCPEBA fee schedule, but not Medicare, SCDHHS adopts the SCPEBA rate.

Second, if a service (code) is not covered by Medicare or SCPEBA, SCDHHS clinical staff will find a service (code) that has a similar description/nature, intensity, and complexity to determine the reimbursement.

Third, if none of the options above are available, SCDHHS will obtain cost data from the provider related to the delivery of the service, and uses the cost data to establish a rate.

The Anesthesiologist will be reimbursed at 60 percent of the Medicaid physician fee schedule rate for providing medical directed supervision of a Certified Registered Nurse Anesthetist (CRNA). The agency's fee schedule rates were set as of July 1, 2019 and are effective for services provided on or after that date. Medicaid bulletins informing the providers of the fee schedule rate changes, as well as the fee schedule itself, are available on the agency's website at http://www.scdhhs.gov/ServiceProviders/FeeSchedules.asp.

Neonatologists and pediatric subspecialists are reimbursed at 140% of the Medicaid Physician fee schedule.

Pediatric sub-specialist providers are those medical personnel that meet the following criteria: a) have at least 85% of their patients who are children 18 years or younger; b) practice in the field of Adolescent Medicine, Cardiology,

Cardiothoracic Surgery, Child Abuse Pediatrics, Critical Care, Emergency Medicine, Endocrinology, Gastroenterology/Nutrition, Genetics, Hematology/Oncology, Infectious Disease, Nephrology, Neurology, Neurological Surgery, Opthamology, Orthopedic Surgery, Otolaryngology, Psychiatry, Pulmonology, Rheumatology, Surgery, Urology and such other pediatric sub-specialty areas as may be determined by the Department of Health and Human Services.

South Carolina Medicaid Supplemental Teaching Physician (STP) Payment Program

South Carolina supplemental teaching physician providers are defined as those providers with teaching physicians who are employed by or under contract with South Carolina Medical Universities and/or their component units. The teaching physician would involve residents and/or medical students in the care of his or her patients or directly supervise residents in the care of patients. The teaching physician must be present within the facility or in the office suite and immediately available to furnish assistance and direction throughout the performance of the service. It does not mean that the teaching physician must be present in the room when the service is performed.

Effective for services provided on and after October 1, 2016, the Medicaid Agency will reimburse teaching physician providers under the Average Commercial Rate (ACR) method. The Medicaid Agency employed the following methodology to determine the payments under the ACR method effective April 1, 2017:

- The base year claims data used for payment services is based upon incurred dates of service from January 1, 2016 through December 31, 2016.

- Next, the STP providers identified and provided a list of their qualifying teaching physicians for the base period.

- Next, each STP provider identified all enrolled Medicaid physicians who are employed by or under contract with the qualifying teaching hospital and/or Medical University and pulled all claims billed by these physicians to their commercial carriers during the base period. The top five commercial carriers would be determined based upon the volume of claims (with charges and payment information provided) incurred by the Medicaid enrolled physicians.

- Next, once the top five commercial carriers were determined by each individual STP provider, the fee schedule rates applicable to the top five commercial carriers were provided via procedure code. To account for changes in commercial fee schedule rates during the base period, providers were allowed to simply weight the rates by the number of months based upon the effective date of the rate change or pull charge and payment data applicable to each claim (including both the commercial carrier payment plus the patient coinsurance, copay, and deductible payments) and determine a weighted average commercial rate over the entire base period.

- Next, Medicaid Agency staff pulled Medicaid claims data incurred during the base period for each teaching physician for each STP provider from its Decision Support System (which is fed from the state's MMIS system). The data was then summarized by each procedure code for each STP provider.

- Next, Medicaid Agency staff determined the average commercial rate for each STP provider by simply taking the average of the commercial rates listed for each procedure code provided.

- Next, Medicaid Agency staff then repriced the individual Medicaid FFS claims from the base period by multiplying the number of units incurred by each procedure code against the individual STP provider's average commercial rate for that procedure code.

- To account for claims with procedure codes with modifiers identified, Medicaid Agency staff repriced these claims based upon the "base procedure code" average commercial rate (i.e. full procedure code rate) multiplied by the modifier logic percentage allowed for the modifier listed. This same logic was also applied to anesthesia claims with modifiers. For claims with procedure codes with unidentifiable modifiers, these claims were priced using the base procedure code average commercial rate. All Medicaid FFS claims with the modifier OTC (technical component) were excluded from the ACR pricing analysis.

- Vaccine administration procedure codes and payments are excluded in the ACR analysis.

- An aggregate IBNR factor is then applied against the annual number of base period Medicaid FFS claims to be repriced by each procedure code to capture all incurred claims applicable to the base period.

- Once all procedure codes were repriced using the average commercial rate, the amounts were summed and compared against the total Medicaid FFS claim payments received by each STP provider. Medicaid FFS claim payments consisted of the payment made by SCDHHS (Medicaid), any TPL that may had been paid on behalf of the patient, and any patient copay amount. This net amount represents the annual supplemental teaching physician payment amount using the ACR payment methodology.

- The annual supplemental teaching physician payment amount described above will be paid to the following supplemental teaching physician providers on a quarterly basis via gross adjustments processed through MMIS: AnMed Medical Center, McLeod Regional Medical Center, Medical University of South Carolina (MUSC) College of Medicine, Self Memorial Hospital, and Spartanburg Regional Medical Center.

6.a Podiatrists' Services:

Reimbursement is calculated at 100 percent of the Medicaid Physician Fee Schedule. The fee schedule payments are the same for both governmental and private providers. Medicaid bulletins informing the providers of the fee schedule rate changes, as well as the fee schedule itself, are available on the agency's website at http://www.scdhhs.gov/ServiceProviders/FeeSchedules.asp.

6.b Optometrists' Services (Vision Care Services):

Reimbursement is calculated at 78% of the 2009 Medicare Physician fee schedule. The fee schedule payments are the same for both governmental and private providers. Medicaid bulletins informing the providers of the fee schedule rate changes, as well as the fee schedule itself, are available on the agency's website at http://www.scdhhs.gov/ServiceProviders/FeeSchedules.asp .

6.c Chiropractor's Services:

Reimbursement is calculated at 100 percent of the Medicaid Physician Fee Schedule. The fee schedule payments are the same for both governmental and private providers. Medicaid bulletins informing the providers of the fee schedule rate changes, as well as the fee schedule itself, are available on the agency's website at http://www.scdhhs.gov/ServiceProviders/FeeSchedules.asp .

6.d Certified Registered Nurse Anesthetist (CRNA): CRNAs under the medical direction of a surgeon will be reimbursed at 90 percent of the Anesthesiologist reimbursement rate. CRNAs under the medical direction of an Anesthesiologist will receive 50 percent of the reimbursement rate. Refer to the Physician Services Section 5, in Attachment 4.19-B. Medicaid bulletins informing the providers of the fee schedule rate changes, as well as the fee schedule itself, are available on the agency's website at http://www.scdhhs.gov/ServiceProviders/FeeSchedules.asp.

Nurse Practitioner: Reimbursement is calculated at 80 percent of the Medicaid Physician fee schedule. The fee schedule payments are the same for both governmental and private providers. Medicaid bulletins informing the providers of the fee schedule rate changes, as well as the fee schedule itself, are available on the agency's website at http://www.scdhhs.gov/ServiceProviders/FeeSchedules.asp.

Physician Assistant: Reimbursement is calculated at 80 percent of the Medicaid Physician fee schedule. The fee schedule payments are the same for both governmental and private providers. Medicaid bulletins informing the providers of the fee schedule rate changes, as well as the fee schedule itself, are available on the agency's website at http://www.scdhhs.gov/ServiceProviders/FeeSchedules.asp.

Psychologists: Psychological services are reimbursed at an established statewide fee schedule as determined in accordance with section 13.d of Attachment 4.19-B.

Registered Dietitian: The state developed fee schedule rate for this service effective on or after April 1, 2013, is $27.82 per encounter and is paid to both private and governmental providers. Medicaid bulletins informing the providers of the fee schedule rate changes, as well as the fee schedule itself, are available on the agency's website at http://www.scdhhs.gov/ServiceProviders/FeeSchedules.asp.

7. Home Health Services:

Nursing Services, Home Health Aide Services, Physical Therapy, Occupational Therapy, Speech Pathology, and Audiology are provided and reimbursed based on the lesser of allowable Medicaid costs, charges, or the Medicaid cost limits as defined in the plan that are based upon Medicare allowable cost definitions and Medicare cost limits. At the end of each Home Health Agency's fiscal year end, an actual cost report must be submitted which is used for the purpose of completing a cost settlement based on the lesser of allowable Medicaid costs, charges, or the cost limits.

Effective for cost reporting periods beginning on or after October 1, 2000, the Medicare per-visit limits used in Home Health rate determinations will be those published in the August 5, 1999 Federal Register for cost reporting periods beginning on or after October 1, 1999. Medical supplies, which are used in the provision of routine home health services, are initially reimbursed on charges; however, during the fiscal year end cost settlement, an adjustment is made reflective of the cost to charges ratio for medical supplies. For all equipment and supplies not routinely provided during the course of a Home Health visit and purchased through a home health agency, the agency will be reimbursed in accordance with Section 12 c of this plan 4.19-B. The payment rate for DME is based on a state specific fee schedule. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The rate was last updated on July 11, 2011. Supplies are exempt from co-payment requirements.

Effective October 1, 2000, Home Health Agencies entering the Medicaid program for the first time will be reimbursed at the lesser of Medicare cost limits based on the per-visit limits as published in the August 5, 1999 Federal Register, charges, or an interim rate established by the Medicaid State Agency until the submission of actual costs.

9. Clinical Services:

Clinic services are preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services that meet all of the following criteria:

- Services provided to outpatients,
- Services provided by a facility that is not part of a hospital, but is organized and operated to provide medical care to outpatients,
- Services furnished by or under the direction of a physician.

Covered clinical services are described in Attachment 3.1-A, page 5 and 5a, of the State Plan. The reimbursement methodologies described in section 9, Clinical Services, have been established to provide adequate payments to the providers of these services.

End Stage Renal Disease- Reimbursement for ESRD treatments, either home or in center, will be an all-inclusive fee based on the statewide average of the composite rates established by Medicare. The reimbursement will be an all-inclusive fee to include the purchase or rental, installation and maintenance of all equipment.

Ambulatory Surgical Centers (ASC)

Services provided in an ASC are reimbursed by means of a facility fee and the physician's professional fee. The reimbursement methodology for the professional component is covered in Section 5 2a.2 of 4.19-B. The facility fee is an all inclusive rate based on payment groups. Each surgical procedure is categorized into one of nine payment groups based on Medicare guidelines for assignment. The facility services covered under the all-inclusive rate include but are not limited to:

1. Nursing services and technical personnel,
2. Facility usage,
3. Drugs, supplies, dressings, splints, appliances related to the provision of surgical procedure,
4. Blood and blood products,
5. Diagnostic or therapeutic services directly related to the provision of a surgical procedure,
6. Administrative services,
7. Anesthesia materials,
8. Intraocular lenses (IOLs),
9. Corneas for transplant.

Exclusions from the inclusive rate include: physician services, laboratory services not directly related to the procedure performed, ambulance services, durable medical equipment for use in the home, leg, arm, back and neck braces, prosthetic devices (except IOLs).

The payment groups and rates were modeled after the Medicare ASC payment methodology prior to HIPAA implementation in 2003. The rates have not been updated since then. ASC rates are published in the "Clinic Services Provider Manual" and are the same for governmental and private providers of this service. The ASC facility fee is 93 percent of the 2003 Medicare Fee Schedule in effect in 2003. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The rate was last updated on July 11, 2011. See page 0a of Attachment 4.19-B.

Multiple surgeries (same day): Multiple surgeries performed during the same operative session will be reimbursed for the procedure that has the highest established rate per the state specific Medicaid ASC facility fee schedule (i.e. that procedure will be considered the primary procedure.) For second and subsequent procedures at the same operative setting, the reimbursement rate will be 50% of the established rate per the state specific Medicaid ASC facility fee schedule.

End Stage Renal Disease (ESRD) Clinics

Services provided in an ESRD clinic are reimbursed for the technical component of services and professional services (i.e. nephrology). The reimbursement methodology for the professional component is covered in Section 5 of 4.19-B. The technical component rate is an all inclusive rate to cover items and services required for the dialysis service provided at the clinic or in the patient's home. Items and services reimbursed in the composite rate include:

1. All equipment, items and services necessary to provide a dialysis treatment,
2. Laboratory tests,
3. Oral vitamins,
4. Antacids/phosphate binders,
5. Oral iron supplements,
6. Nutritional supplements,
7. Staff time required to provide treatment.

Freestanding and hospital based certified ESRD clinics are reimbursed using the methodology described in this section. However, outpatient hospital dialysis services are billed on the UB claim form and reimbursed under the outpatient hospital payment methodology described in section 2a of Attachment 4.19-B.

The all inclusive fee is based on the statewide average of the composite rates established by Medicare. ESRD fee schedules and updates are published in the "Clinic Services Provider Manual" and are the same for governmental and private providers of this service. Payment to free standing ESRD clinics is 96 percent of the 2003 Medicare Fee Schedule. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The agency's fee schedule rate was set as of July 11, 2011 and is effective for services provided on or after that date. All rates are published on the agency's website at www.scdhhs.gov. See page 0a of Attachment 4.19-B.

Mental Health Clinics

Community mental health providers provide clinic services as defined in federal regulations 42 CFR 440.90. Community mental health services are provided to adults and children diagnosed with a mental illness as defined in the current addition of the Diagnostic Statistical Manual (DSM).

MEDICAID BILLABLE SERVICES (Community Mental Health Clinics):

The following table includes Community Mental Health program services typically billed to Medicaid.

Services and Approved Abbreviation	Procedure Code	Unit Time	Maximum Units/Day
Behavioral Health Screening - Alcohol/Drug	H0002 HF	15 minutes	2
Crisis Intervention Service (CI)	H2011	15 minutes	20
Family Therapy, client not present	90846	Encounter	1 per day
Family Therapy, client present (Fm Tx)	90847	Encounter	1 per day
Group Therapy (Gp Tx)	90853	Encounter	2 per day
Individual Therapy (Ind Tx)	90804	Encounter	1 per day
MH Assessment by Non Physician (Assmt) Assessment - MHP (Assess.)	H0031	30 minutes	8
MH Service Plan Development by Non Physician (SPD)	H0032	15 minutes	2
Nursing Services (NS)	T1002	15 minutes	7
Psychiatric Medical Assessment (PMA)MD - Adult	90792	Encounter	1 per day
Psychiatric Medical Assessment (PMA)MD - Child	90792 HA	Encounter	1 per day
Psychiatric Medical Assessment-Advanced Practice Registered Nurse (PMA-APRN)	90792 Adult (SA) Child (HW)	Encounter	1 per day

Services and Approved Abbreviation	**Procedure Code**	**Unit Time**	**Maximum Units/Day**
Psychiatric Medical Assessment – Telepsychiatry (PMA-T)	90792 GT	Encounter	1 per day
Medical Evaluation and Management for established – MD	99213	15 minutes	1 per day
Medical Evaluation and Management for Established – APRN	99213 with modifier SA	15 minutes	1 per day
Medical Evaluation and Management for Established – Telepsychiatry	99213 with modifier GT	15 minutes	1 per day
Medical Evaluation and Management for Established – MD	99214	30 minutes	1 per day
Medical Evaluation and Management for Established – APRN	99214 with modifier SA	30 minutes	1 per day
Medical Evaluation and Management for Established – Telepsychiatry	99214 with modifier GT	30 minutes	1 per day
Medical Evaluation and Management for Established – MD	99215	40 minutes	1 per day
Medical Evaluation and Management for Established – APRN	99215 with modifier SA	40 minutes	1 per day
Medical Evaluation and Management for Established – Telepsychiatry	99215 with modifier GT	40 minutes	1 per day
Team Conference Face-to-Face Non-Physician	99366	Encounter	1 per day
Team Conference Face-to-Face Physician	99367	Encounter	1 per day
Psychotherapy	90833	30 minutes when performed with E&M	1 per day
Psychotherapy	90836	45 minutes when performed with E&M	1 per day
Psychotherapy	90838	60 minutes when performed with E&M	1 per day
Multi-Family Group Psychotherapy	90849	Encounter	1 per day

Injection Administration (96372) provided during a clinic setting will be reimbursed via the SC Medicaid Physician Fee schedule.

Effective for services provided on or after October 1, 2012, state owned governmental providers of community mental health clinic services will receive prospective payment rates based upon its 2010 fiscal year end Medicaid cost report. In order to trend the cost of each service to the initial payment period of October 1, 2012 through June 30 2013, the Medicaid Agency will employ the midpoint to midpoint methodology and the use of the CY 2010 Medicare Economic Index (1.2%). Effective for services provided on or after July 1, 2016, the SC Department of Mental Health providers of community mental health services will receive prospective payment rates based upon its 2015 fiscal year end Medicaid cost report. In order to trend the cost of each service to the payment period of July 1, 2016 through June 30, 2017, the Medicaid Agency will employ the midpoint to midpoint methodology and the use of the 3rd Quarter 2015 Global Insight Indexes of the CMS Medicare Economic index as well as the state of South Carolina cost of living increase provided to state employees effective July 1, 2016. State owned governmental providers of community mental health clinic services will be required to submit annual cost reports when certified public expenditures are used as the source of state matching funds.

Effective for services provided on and after July 1, 2017, the July 1, 2016 SCDMH clinic rates were increased by the calendar year 2017 Medicare Economic Index trend rate of 1.2%.

Interim Rates

Medicaid interim rates for mental health services in community mental health centers are established utilizing Medicare reasonable cost principles, as well as criteria outlined under 45 CFR Part 75 and 42 CFR Part 413. Costs reimbursable in the rates for mental health clinical services include but are not limited to:

1. Personnel costs – the salary and fringe benefit costs associated with direct line staff, meeting credentialing requirements, providing the services in the community mental health centers,

2. Clinical supervision – the salary and fringe benefit cost associated with the clinical supervision of these services,

3. Supplies – material and supply costs that are required for direct services to patients,

4. Training and travel – training and associated travel expenses that directly relate to maintaining certification, qualifications, or licensure required to render contracted mental health services but not to obtain their initial certification,

5. Indirect costs – Overhead/administrative costs incurred by mental health clinics and state agencies that are allocable to the individual mental health services via approved cost allocation methodologies as allowed under 45 CFR Part 75 and 42 CFR Part 413.

Annual Cost Identification and Certified Public Expenditure (CPE) Reconciliation Process for State Owned governmental providers:

Each State Owned governmental provider rendering clinical mental health services will be required to submit a CMS approved annual cost report to establish the costs of their services. Allowable costs will be accumulated by service definition. Costs by service will be accumulated for the total population of users of the service (i.e. regardless of the source of payment). Allowable costs will be classified as follows and determined in accordance with Medicare reasonable cost principles and criteria outlined under 45 CFR Part 75 and 42 CFR Part 413.

Direct Costs:

1) Personnel costs – Expenditures from the accounting records of the State Agency for the incurred salaries, payroll taxes, and fringe benefits for the employees providing direct medical services to beneficiaries in the Community Mental Health clinics. For employees who are not assigned to work 100% of their time in clinical services, time sheets will be required to allocate salary, payroll taxes and fringe benefits,

2) Materials, supplies (excluding injectibles), and non-capital related equipment expenditures required by the practitioners for the provision of service. The following characteristics determine the charging of supplies to a medical service:

    a) commonly provided in the course of care/treatment by the practitioner without additional charge,
    b) provided as incidental, but integral to the practitioners' services, and
    c) used by the "hands-on" medical provider,

3) Training and travel expenses that directly relate to maintaining certification, qualifications, or licensure for case managers but **not** to obtain their initial certification.

Supervision:

Costs of supervisory staff will be added to the direct costs associated with practitioners of specific services and will be determined in accordance with cost allocation methodologies as allowed in accordance with criteria outlined under 45 CFR Part 75 and 42 CFR Part 413.

Indirect Costs:

Allowable indirect costs will be determined and allocated in accordance with cost allocation methodologies as allowed in the 45 CFR Part 75 and 42 CFR Part 413.

The results of total allowable costs divided by total units of service per service definition become the average allowable unit rates for CPE purposes. The average allowable unit rates for each service are multiplied by the applicable Medicaid units of service (as determined by the SCDHHS MMIS).These results are summed to become the annual allowable Medicaid reimbursement for the governmental provider. This aggregate amount is compared to aggregate Medicaid interim payments (including TPL) and any prior adjustments and/or recoupments for these services.

Settlement Procedures (Community Mental Health Providers):

Should the comparison referred to above identify an overpayment to the provider, the SCDHHS will recoup the federal share of the overpayment and return it to CMS. Should the comparison referred to above identify an underpayment to the provider, no further payment will be made by SCDHHS.

Outpatient Pediatric Aids Clinics

Outpatient Pediatric Aids Clinics (OPACs) provide specialty care, consultation and counseling services for HIV-infected and exposed Medicaid children and their families. OPACs provide services that are medical, behavioral, psychological and psychosocial in nature. Effective July 1, 1993, Outpatient Pediatric Aids Clinics (OPACs) are a recognized provider type in the Medicaid Program. Services performed in OPACs effective October 1, 2014 are reimbursed according to existing Medicaid fee schedules found under the various covered Medicaid services contained within Attachment 4.19-B as follows: physician services – section 5.; laboratory services – section 3., registered dietitian services – section 6.d; rehabilitative services – section 13.d and; case management services – section 19.

The Medicaid Agency will unbundle the previously bundled CPT codes applicable to the individual OPAC service(s) being rendered (i.e. medical or behavioral/psychological) for future pricing purposes.

Infusion Centers

Infusion centers allow Medicaid beneficiaries to receive various types of infusion therapy in a facility setting other than a physician's office or outpatient hospital. Infusion centers must have the ability to perform the following services:

Chemotherapy,
Hydration,
IGIV,
Blood and blood products,
Antibiotics,
Intrathecal/lumbar puncture,
Inhalation,
Or therapeutic phlebotomy.

Effective calendar year 2003, Infusion Centers are a recognized provider type in the Medicaid Program. Services performed in Infusion Centers are reimbursed according to existing Medicaid fee schedules found under the various covered Medicaid services contained within Attachment 4.19-B as follows: physician services – section 5 and drugs (including J codes and blood/blood products) – section 12.

10. Dental Services:

Reimbursement to providers of dental services is made on the basis of an established fee schedule not to exceed prevailing charges in the state. Reimbursement will be provided on a per procedure basis. Reimbursement for dental services shall be based on a percentage of published usual and customary South Carolina dental rates, not to exceed the 75th percentile of usual and customary reimbursement for South Carolina. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The agency's fee schedule rate was set as of July 1, 2017 and is effective for services provided on or after that date. Rates for Preventive, Oral Surgery and Ancillary services were updated on July 1, 2017. The rates for all other dental services were set as of July 11, 2011. All rates are published on the agency's website at www.scdhhs.gov.

Pregnant women, individuals participating in family planning services, infants and children up to age 19 will not be subject to co-pay.

11.a. & 11.b. Physical Therapy/Occupational Therapy:

Payment will be according to an established fee schedule as based on the methodology outlined in the Physician Section 5, Attachment 419-B, Page 2a.2. The Physician Services fee schedule rates are effective for services provided on or after the implementation date as outlined in the Physician Section 5, Attachment 419-B, Page 2a.2. Medicaid Bulletins informing the providers of the fee schedule rate changes, as well as the fee schedule itself, are available on the agency's web site at http://www.scdhhs.gov/ServiceProviders/FeeSchedules.asp.

The SCDHHS does not publish a fee schedule for Hospitals and Home Health services. The payment methodology for Hospital Services can be found at 4.19-B page 1a.1 and Home Health can be found at 4.19-B page 3.1.

11.c. Speech/Language and Audiological Services:

Payment will be according to an established fee schedule as based on the methodology outlined in the Physician Section 5, Attachment 419-B, Page 2a.2. The Physician Services fee schedule rates are effective for services provided on or after the implementation date as outlined in the Physician Section 5, Attachment 419-B, Page 2a.2. Medicaid Bulletins informing the providers of the fee schedule rate changes, as well as the fee schedule itself, are available on the agency's web site at http://www.scdhhs.gov/ServiceProviders/FeeSchedules.asp.

The SCDHHS does not have a published fee schedule for Hospitals and Home Health services. The payment methodology for Hospital Services can be found at 4.19-B page 1a.1 and Home Health can be found at 4.19-B page 3.1.

12.a. Prescribed Drugs:

Medicaid pays for FDA approved prescribed drugs with stated exceptions described in Attachment 3.1-A, Item 12-A, Limitation Supplement.

4. Basis for Payment:

A. MULTIPLE SOURCE DRUGS

Reimbursement for covered multiple-source drugs in the Medicaid program shall be limited to the lowest of:

(1) The Federally-mandated upper limit of payment or South Carolina Maximum Allowable Costs (SCMAC), plus the current dispensing fee; or

(2) The South Carolina Estimated Acquisition Cost (SCEAC) which is the average wholesale price (AWP) less the current discount rate (16%), plus the current dispensing fee; or

(3) The South Carolina Estimated Acquisition Cost (SCEAC which is the wholesale acquisition cost (WAC) plus (0.8%) plus the current dispensing fee: or

(4) The provider's usual and customary charge to the public for the prescription as written for the brand actually dispensed.

B. OTHER DRUGS

Reimbursement for covered drugs other than the multiple-source drugs with CMS upper limits shall not exceed the lower of:

(1) The South Carolina Estimated Acquisition Cost (SCEAC), which is the average wholesale price (AWP), less the current discount rate (16%), plus the current dispensing fee; or

(2) The South Carolina Estimated Acquisition Cost (SCEAC which is the wholesale acquisition cost (WAC) plus (0.8%) plus the current dispensing fee: or

(3) The provider's usual and customary charge to the public for the prescription as written for the brand actually dispensed.

340B Providers

For prescription drugs purchased through the 340B program and provided by a covered entity, payment shall be limited to the provider's actual acquisition cost for purchasing the medication plus a professional dispensing fee of $10.50.

Drugs acquired through the 340B drug pricing program and dispensed by 340B contract pharmacies are not covered.

For drugs purchased outside of the 340B program, reimbursement shall be determined using the Standard Basis for Payment.

C. PRODUCTS WITHOUT AN AWP WHOSE PRICE INCLUDE OTHER SERVICES

For pharmaceutical products having no AWP and whose billing price includes services other than ingredient cost, the state will impute its EAC based on available data. Final reimbursement is based on the imputed EAC plus the current dispensing fee. Only the provider actually rendering the service can be reimbursed; however, in cases where a single payment is made for several medically necessary services provided by one entity, the state will allocate the components of the payment to the particular Medicaid benefit with which they are associated.

2. DEFINITIONS:

A. UPPER LIMITS OF PAYMENT (42CFR 447.331)

The upper limit of payment for certain multiple source drugs is the amount designated by HCFA or the South Carolina program – whichever is less. Payment for these drugs, in the aggregate, cannot exceed those limits set by CMS.

B. SOUTH CAROLINA ESTIMATED ACQUISITION COST (SCEAC)

SCEAC is defined as the State's closest estimate to the price generally and currently paid by providers for specific drugs, based on the package size of drugs most frequently purchased by providers. EAC established by South Carolina is the AWP (Average Wholesale Price) minus 16%. The AWP used in calculating the SCEAC is furnished by a contracted pricing source.

3. MULTIPLE SOURCE DRUG REIMBURSEMENT LIMITATION/PHYSICIAN OVERRIDE

A physician may prescribe a brand name of a multiple source drug that bears a higher cost than the upper limit established by HCFA or South Carolina but reimbursement is available only if the prescription has the physician's certification (in his own handwriting) that the specific brand is medically necessary for a patient. The prescriber must also complete a South Carolina Medicaid MedWatch form documenting that the treatment failure is attributed to the generic product.

4. CO-PAYMENT FOR PRESCRIPTIONS:

Prescriptions filled by dispensing physicians are not subject to co-payment.

5. DISPENSING FEE:

Dispensing fees are determined on the basis of surveys that are conducted periodically and take into consideration pharmacy operational costs (overhead, professional services, and profit in different types of pharmacies).

The current dispensing fee is $3.00 for independent pharmacy providers; $3.00 for institutional pharmacy providers; no dispensing fee for dispensing physicians.

Dispensing fees are paid to the following type providers:

"Free-Standing contracting pharmacies not otherwise reimbursed by Medicaid for others service on a cost basis.

"In-House" pharmacies reimbursed by Medicaid on a cost basis for other services.

Dispensing physicians are reimbursed only for the cost of the drug.

Additional Upper Limit Application:

The upper limits are described in this Attachment Section also apply in cases where prescribed drugs are furnished as part of SNF or ICF services or under prepaid capitation arrangements. Contracts between the State Agency and the underwriter, carrier, foundation, HMO or other insurers containing the terms of such prepaid capitation arrangements shall include a provision imposing the same upper limits for reimbursement or prescribing drugs.

12.c Prosthetic Devices and Medical Supplies, Equipment and Services:

Certain medical services, supplies, and equipment (including equipment servicing) that do not generally vary significantly in quantity will be reimbursed at a rate not to exceed the rate established by the Medicare carrier in the area at the lowest charge level at which the service, supplies, and equipment are widely and consistently available within their locality according to the procedures prescribed in 42 CFR 405.511. A list of these items of service is published in the federal regulations. This upper limit is applicable to such services furnished under both Medicare and Medicaid.

For selected services and items furnished only under Medicaid (and identified and published by the Secretary of HHS by regulations), the Medicaid agency must calculate the lowest charge levels under the procedures specified in 42 CFR 405.511© and (d), and limit payments to that amount.

Pregnant women, individuals participating in family planning services, infants and children up to age 19 will not be subject to co-pay.

Hearing Aids – A consolidated contract between the Department of Health and Human Services (DHHS) and Department of Health and Environmental Control (DHEC) is in effect to provide hearing aids, accessories and repair to eligible Medicaid recipients 21 years old and under using S-codes.

Home Dialysis – Reimbursement for equipment and supplies are included in the all-inclusive rate paid only to the End Stage Renal Dialysis Clinic.

12.d Eyeglasses

Eyeglass services are covered for lenses, frames and other services as outlined in the Physician, Laboratories, and Other Medical Professionals manual to recipients under the age of 21. These services are provided by enrolled retail optical establishments or self-employed ophthalmic dispensers (opticians). Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of eyeglasses. Providers of eyeglasses and contact lenses are reimbursed the lesser of the providers billed charges or fees determined by SCDHHS, which are based on a review of Medicare fees and/or other data available to SCDHHS, such as relevant cost or fee surveys. The agency's fee schedule rate was set as of January 1, 2014 and is effective for services provided on or after that date. All rates are published on the agency's website at www.scdhhs.gov.

13.b The cancer screening services are reimbursed on the Physician Services fee schedule. The Physician Services fee schedule rates are effective for services provided on or after the implementation date as outlined in the Physician Section 5, Attachment 4.19-B. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The agency's fee schedule rate was set as of July 11, 2011 and is effective for services provided on or after that date. All rates are published on the agency's website at www.scdhhs.gov.

13.c Preventive Services

Preventive services for Primary Care Enhancement as defined in 3.1-A, pages 6.1a and 6a, paragraph 13.c. must be provided by a physician or other licensed practitioner of the healing arts as required by 42 CFR 440.130(c). The following services will be reimbursed by Medicaid as a preventive service for Primary Care Enhancement:

(A) - Individual preventive services for Primary Care Enhancement provided by a professional (unit of service - 15 minutes)
(B) - Group preventive services for Primary Care Enhancement provided by a professional (unit of service - 15 minutes)
(C) - Assessment provided by a professional (unit of service - 15 minutes)

Effective for services provided on or after October 1, 2012, Medicaid reimbursement rates for preventive services for Primary Care Enhancement will be established at eighty percent (80%) of the 2012 South Carolina Medicare Physician Fee schedule rates for diabetes outpatient self-management training and converted to 15 minute units. Therefore, eighty percent of G0108 will be used to establish the individual service rate while eighty percent of G0109 will be used to establish the group service rate. Both private and governmental providers will receive these rates.

Preventive Services - Disease Management

The disease management program is a preventive service that provides coverage under the Categorically Needy Program (CNP) to all Medicaid beneficiaries who receive services through the South Carolina Medicaid fee-for-service (FFS) system, including those who have one or more of the following diseases: Asthma, Diabetes, or Hypertension.

In accordance with federal interpretation, the disease management contracts are risk contracts. The method of payment has been developed using actuarially sound methodology per 42 CFR438.6 (c).

The State will pay the DMOs a per member per month capitated fee based on the total eligible population, and the prevalence of each disease within the total population.

The State expects a minimum, annual net cost savings of five percent (5%) in the overall medical costs of those beneficiaries with asthma, diabetes or hypertension. The guaranteed, annual net savings is defined as total savings minus SCDHHS expenditures on disease management services under the contract.

If the amount of guaranteed minimum, annual net savings is not achieved, the DMOs will pay the difference between the guaranteed minimum, annual net savings and the actual net savings to the SCDHHS. The DMOs will also be required to forfeit their fees.

13.d Rehabilitative Services

Rehabilitative behavioral health services are medical or remedial services that have been recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice, under South Carolina State Law and as may be further determined by the South Carolina Department of Health and Human Services (SCDHHS) for maximum reduction of physical or mental disability and restoration of a beneficiary to their best possible functional level. The following services are considered Medicaid Rehabilitative services:

Behavioral Health Screening, Behavior Modification, Crisis Management, Diagnostic Assessment, Family Therapy, Family Support, Group Therapy, Individual Therapy, Medication Management, Peer Support Services, Rehabilitative Psychosocial Services, Service Plan Development, Substance Abuse Counseling, and Substance Abuse Examination.

In order to develop Medicaid payment rates by provider type (i.e. practitioner) for each service listed above, the Medicaid Agency employed the following reimbursement methodology:

1. First, the agency developed annual compensation amounts for each provider type:

   - Salary data was obtained from the South Carolina Office of Human Resources (SCOHR) Classifications Manual (midpoint per position salary data) as well as the May 2008 South Carolina Occupational Employment and Wage Estimates from the United States Department of Labor (mean salary data). For unclassified professional positions that are not identified within the SCOHR Classification Manual, provider compensation amounts were obtained from applicable providers.

- Provider information reflecting the professionals that would be providing the different rehab services were utilized to match the appropriate SCOHR position classifications. An average of the identified midpoint salary classification was utilized to reflect the public compensation when more than one classification applied to the service.

- Mean salary data obtained from the Department of Labor Survey identified above was utilized to estimate the private compensation levels of each provider type based upon provider information reflecting the professionals that would be providing the different rehab services. An average of the identified mean salary classification was utilized to reflect the private compensation when more than one classification applied to the service.

- To determine the overall average annual compensation amounts for each provider type, the Medicaid Agency simply averaged the annual compensation amounts determined under the public compensation method and the private compensation method.

- After completing the individual average annual compensation level for each provider type, the following provider types were classified under one of the following educational levels to determine an overall average annual compensation amount for each educational level. The provider titles of Psychiatrist, Physician, Pharmacist, Psychologist, Physician Assistant, Advanced Practical Registered Nurse, Registered Nurse, Licensed Practical Nurse are not classified according to educational level but rather establish their own provider specific average annual compensation level.

PROVIDER TYPE	EDUCATIONAL LEVEL
Licensed Independent Social Worker – Clinical Practice (LISW – CP)	Masters Level
Licensed Independent Social Worker – Advanced Practice (LISW – AP)	Masters Level
Licensed Masters Social Worker (LMSW)	Masters Level
Licensed Marriage and Family Therapist (LMFT)	Masters Level
Licensed Professional Counselor (LPC)	Masters Level
Certified Substance Abuse Professional	Masters Level

PROVIDER TYPE	EDUCATIONAL LEVEL
Clinical Chaplain	Masters Level
Mental Health Professional (MHP)	Masters Level
Behavior Analyst- Masters Level	Masters Level
Licensed Bachelor of Social Work (LBSW)	Bachelors Level
Substance Abuse Specialist	Bachelors Level
Behavior Analyst- Bachelors Level	Bachelors Level
Certified Substance Abuse Professional (SAP)	Bachelors Level
Child Service Professional	Bachelors Level
Mental Health Specialist	High School Level
Peer Support Specialist (PSS)	High School Level

- As
- As a result of the above methodology, annual compensation amounts were determined for the following provider types and educational levels: Psychiatrist, Physician, Pharmacist, Psychologist, Physician Assistant, Advanced Practical Registered Nurse, Registered Nurse, Licensed Practical Nurse, Masters Level, Bachelors Level, and High School Level.

2. Next, the Medicaid Agency determined the maximum number of billing hours that could be anticipated for each provider type for each billable service. Assuming a billing productivity factor of 50%, the maximum number of billing hours for each provider type was calculated to be 975 hours. The calculation is as follows – 37.5 hours per week x 52 weeks x 50% = 975 hours.

3. Next, the annual compensation amounts determined in (1) above are divided by the maximum number of billable hours as determined in (2) above to arrive at an hourly billing compensation rate for each provider type.

4. Next, the initial hourly billing compensation rate for each provider type as identified in (3) above is increased by 30% to take into account the cost of fringe benefits. The fringe benefit allocation percentage is representative of state government fringe benefit allowances.

5. Next, once the initial hourly billing compensation rate is increased by the fringe benefit allowance of 30% as determined in (4) above, it is multiplied by an indirect cost rate of 10% to arrive at an adjusted hourly billing rate by provider type. An indirect rate is applied to compensate the provider for overhead costs.

6. Next, once the hourly billing rate has been adjusted for indirect cost as determined in (5) above, a supervision adjustment factor of 10% is then applied to the provider types which require supervision in accordance with the requirements of the Rehabilitative Service definitions as outlined under Attachment 3.1-A. The provider types affected include: Registered Nurses, Licensed Practical Nurses, and all Masters Level, Bachelors Level, and High School Level professionals.

7. Next, in order to account for level of effort of providing specific rehab services by provider type, a work adjustment factor will be applied to the hourly billing rate previously adjusted for provider supervision as determined in step (6). Level of effort is defined based on the work unit component of the 2009 Medicare RBRVS. Level of effort relativity factors were developed by mapping therapy services types based upon the definition of the target service type to the definition of the CPT procedure codes in the applicable procedure code list (as defined by the CPT 2009 Professional Edition, published by the American Medical Association and Stedman's CPT Dictionary, second edition, published by the American Medical Association). The level of effort adjustment was developed by dividing the work units for each of the procedure codes by the overall average work units for the universe of target procedure codes (90804 to 90862, 99367, 99368, and 99204). For several service categories, codes were combined and composite results were utilized. Procedures were grouped for family therapy, assessments, services with evaluation and management components, and services with evaluation and management components. In addition, clinical judgments were made with respect to:

   * For level of effort for service types between physicians and other professional providers relative to para-professionals.

   * For differences between CPT code definitions and the services to be provided.

8. Finally, to determine the Medicaid rate of each provider type for each rehab service that the provider type is authorized to render, the hourly billing rate as determined in step (7) will be divided by each service's unit of measurement.

Psychological Training and Testing services provided by psychologists will be reimbursed at one hundred percent of the 2006 version of the South Carolina Medicare Physician Fee Schedule.

Medication administration services (i.e. injectibles and injectibles administration) rendered in conjunction with certain rehabilitative services identified above will be reimbursed in accordance with the South Carolina Physician Fee Schedule in effect at the time of service.

The Medicaid agency will reimburse private providers of rehabilitative services using Medicaid rates which are calculated in accordance with the rate setting methodology previously described. Also, interim Medicaid

payments for state owned and non-state owned governmental providers of rehabilitative services will be based upon the Medicaid rates previously described by practitioner level. Except as otherwise noted in the plan, state-developed fee schedule rates and unit measures are the same for both governmental and private providers of Rehabilitative Behavioral Health Services. The agency's fee schedule was set as of July 1, 2010 and is effective for services provided on or after that date. All fee schedule rates and unit measures are published at https://www.scdhhs.gov/resource/fee-schedules. State owned and non-state owned governmental providers will be reimbursed at one hundred percent of their allowable Medicaid costs based upon the review and reconciliation of annual cost reports.

Therapeutic Foster Care

Effective for services provided on or after July 1, 2020, the Medicaid Agency will convert the provision of psychosocial rehabilitation services (PRS) from a fifteen-minute unit of service to a per diem basis for Child Placing Agencies serving children in Therapeutic Foster Care (TFC) placement under contract with the South Carolina Department of Social Services. Three different TFC treatment level (i.e. per diem) rates will be established to account for variances relating to the number of daily service units provided to TFC Children. The rate setting process for this service is provided as follows:

- First, the base data used represented the December 2019 historical expenditure/utilization data of TFC children receiving PRS services, which was subjected to a review of SFY 2019 as well as November 2019 historical expenditure/utilization data for consistency purposes.

- Next, a cost per PRS unit delivered was developed which reflected the average historical blend of PRS daily service units provided by master level, bachelor level, and less than bachelor level professionals.

- Next, TFC levels are established based upon service utilization only. Therefore each TFC level was established based upon a review of the most prevalent daily units billed within each assigned TFC level.

- Finally, to determine the TFC level per diem rates, the cost per PRS unit determined in bullet #2 was multiplied by the average number of daily units determined for each TFC level as defined in bullet #3. Level I = 4.6 units; Level II = 7.0 units and; Level III = 10.0 units.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The agency's fee schedule rate was set as of July 1, 2020 and is effective for services provided on or after that date. All rates are published at the following SCDHHS website address: https://www.scdhhs.gov/resource/fee-schedules.

Annual Cost Identification and Reconciliation Process for State Owned and Non-State Owned governmental providers:

Each State Owned and Non-State Owned governmental provider rendering rehabilitative behavioral health services will be required to submit a CMS approved annual cost report to establish the costs of their services. Allowable costs will be accumulated by practitioner and service definition. Costs by practitioner by service will be accumulated for the total population of users of the service (i.e. regardless of the source of payment). Allowable costs will be classified as follows:

Direct Costs:

1) Directly chargeable salary costs of the practitioner(s) providing the service and associated fringe benefits,
2) Materials, supplies excluding injectibles, and non-capital related equipment expenditures required by the practitioners for the provision of service,
3) Required training and any associated travel costs of the practitioners, and
4) Any costs not noted above but directly assignable excluding subcontract arrangements for direct service delivery and costs included in indirect cost determination.

Supervision:

Costs of supervisory staff will be added to the direct costs associated with practitioners of specific services. Allowability of supervisory costs is determined based on the practitioners requiring supervision in accordance with the Rehabilitative Service definitions as outlined under Attachment 3.1-A. The provider types affected include: Registered Nurses, Licensed Practical Nurses, and all Masters Level, Bachelors Level, and High School Level professionals. Time and effort reports completed in accordance with HIM-15, Chapter 2300, Section 2313.2 (E) will be used to determine supervision costs.

Indirect Costs:

Allowable indirect costs can be determined in one of two ways:

1. The application of the provider’s federally approved indirect cost rate (or federally approved cost allocation plan) or

2. An allocation of administrative/overhead costs as allowed in accordance with 45 CFR Part 75 and 42 CFR Part 413. This option will only be available for those state agencies that provide institutional and acute care services and file these costs via Medicare cost reports.

Total Allowable Costs by service by practitioner:

The allowable costs for a rehabilitative behavioral health service by practitioner will be the sum of allowable direct costs, supervisory costs as applicable, and the determination of indirect costs as determined above.

Service/Practitioner Statistics:
The State Owned and Non-State Owned governmental providers will be required to accumulate and report service utilization statistics (i.e. units of service) for the total universe of service recipients in keeping with the accumulation of costs by total population of users.

Reconciliation of Annual Cost Reports to Interim Payments:
Annual cost reports will be desk reviewed for accuracy and compliance with 45 CFR Part 75 and 42 CFR Part 413 cost definitions and principles. The result of total allowable costs (per service and practitioner) divided by total units of service (as defined above) result in the average allowable unit rate for reconciliation and cost settlement. The average allowable unit rate multiplied by Medicaid units of service (as determined by the SCDHHS MMIS) becomes annual allowable Medicaid reimbursement for the governmental provider. This amount is compared to Medicaid interim payments (including TPL) and any prior adjustments and/or recoupments for these services. Should this comparison identify an overpayment to the provider, SCDHHS will send a letter to the provider requesting repayment within 30 days. Should the comparison identify an underpayment, an adjustment is processed through the MMIS to pay the provider the difference.

Services such as medication administration and psychological training and testing reimbursed in accordance with the applicable South Carolina Medicare Physician Fee Schedule will not be subject to retrospective cost settlement.

Rehabilitative Services for Primary Care Enhancement as defined in 3.1-A, pages 6c.31 and 6d, paragraphs 13d. A, B, C and D may be provided by a physician or other licensed practitioner of the healing arts, or under the direction of a physician or other licensed practitioner of the healing arts as permitted by 42 CFR 440.130(d). The following services will be reimbursed by Medicaid as a rehabilitative service for Primary Care Enhancement:

(A) Individual rehabilitative services for Primary Care Enhancement provided by a professional or a paraprofessional (unit of service - 15 minutes)

(B) Group rehabilitative services for Primary Care Enhancement provided by a professional or a paraprofessional (unit of service - 15 minutes)

(C) Assessment provided by a professional (unit of service - 15 minutes)

Effective for services provided on or after October 1, 2012, Medicaid reimbursement rates for preventive services for Primary Care Enhancement will be established at eighty percent (80%) of the 2012 South Carolina Medicare Physician Fee schedule rates for diabetes outpatient self-management training and converted to 15 minute units. Therefore, eighty percent of G0108 will be used to establish the individual service rate while eighty percent of G0109 will be used to establish the group service rate. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The agency's fee schedule rate was set as of July 11, 2011 and is effective for services provided on or after that date. All rates are published on the agency's website at www.scdhhs.gov.

Bundled Rehabilitative Services - Substance Abuse and Addictive Disorders

The bundled services described below are provided to adults and children to provide interventions for the treatment and management of substance abuse and addictive disorders in an outpatient or residential setting. The payment methodology described below is applicable to private and governmental providers.

MEDICAID BILLABLE SERVICES:

The following table includes bundled services billed to Medicaid.

Services	Procedure Code	Unit Time
Alcohol and/or Drug Services-Sub-acute Detox Residential-Clinically Managed Residential Detoxification-Level III.2-D	H0010	Per Diem
Alcohol and/or Drug Services-Acute Detox Residential – Medically Monitored Residential Detoxification Services - Level III.7-D	H0011	Per Diem
Behavioral Health-Long-Term Residential Treatment Program –Clinically Managed High-Intensity Residential Treatment – Level III.5-R	H0019	Per Diem
Behavioral Health-Short-Term Residential Treatment Program – Medically monitored Intensive Residential Treatment – Level III.7-R	H0018	Per Diem
Behavioral Health-Short-Term Residential Treatment Program –Medically Monitored High Intensity Residential Treatment Services – Level III.7-RA	H0018 HA	Per Diem
Alcohol and/or Drug Treatment - Day Treatment/Partial Hospitalization – Level II.5	H2035	60 minutes
Alcohol and/or Drug Services - Intensive Outpatient Treatment – Level II.1	H0015	60 minutes

Bundled Medicaid reimbursement rates for providers providing the services outlined above are established utilizing Medicare reasonable cost principles, as well as OMB Circular A-87. In order to establish the prospective bundled services payment rates, the agency first employed the use of the SCDAODAS state fiscal year 2010 cost reports which provided the allowable Medicaid reimbursable costs of the bundled services by procedure code. Allowable Medicaid costs which were used in the development of the prospective bundled rates would include the following:

Direct Costs:

Personnel costs – Expenditures from the accounting records of the State Agency for the incurred salaries, payroll taxes, and fringe benefits for the employees providing direct medical services to beneficiaries. For employees who are not assigned to work 100% of their time in providing services, time sheets will be required to allocate salary, payroll taxes and fringe benefits,

1) Materials, supplies (excluding injectibles), and non-capital related equipment expenditures required by the practitioners for the provision of service. The following characteristics determine the charging of supplies to a medical service:

   a) commonly provided in the course of care/treatment by the practitioner without additional charge,

   b) provided as incidental, but integral to the practitioners' services, and

   c) used by the "hands-on" medical provider,

2) Training and travel expenses that directly relate to maintaining certification, qualifications, or licensure but **not** to obtain their initial certification, and

3) Any costs not noted above but directly assignable, excluding subcontract arrangements for direct service delivery and costs included in indirect cost determination.

Costs relating to room and board, as well as its allocation of administrative/overhead cost, are excluded from allowable costs for Medicaid rate setting purposes. Therefore, room and board costs are not considered in the calculation of the provider payment rates under each setting. Room and board costs would include, but not be limited to, facility costs, utilities, property insurance, dietary costs, laundry costs, housekeeping costs, maintenance costs, and any personnel and related fringe cost of staff that are on-site overnight or throughout the day providing patient oversight.

Supervision:

Costs of supervisory staff will be added to the direct costs associated with practitioners of specific services. The allowability of supervisory costs is determined based on time and effort reports which will identify and separate administrative activities of the supervisor versus those activities that are service oriented (i.e. participating in assessment and care plan meetings, participation in follow-up and re-evaluation activities). Time and effort reports completed in accordance with HIM-15, Chapter 2300, Section 2313.2 (E) will be used to determine clinical supervision costs.

Administrative/Overhead Costs:

Allowable administrative/overhead costs of the provider are allowed in accordance with Medicare reasonable cost principles and cost allocation methodologies as described in Provider Reimbursement Manual HIM-15.

Once total allowable Medicaid costs are accumulated for each bundled service, the costs are then divided by total units of service per service definition to become the state fiscal year 2010 baseline rate. In order to trend the state fiscal year 2010 baseline rates to state fiscal year 2013, a trend factor of 1% per year was employed. The trend factor utilized was based on South Carolina non-farm wage inflation published by the Bureau of Labor Statistics. In order to test the reasonableness of the bundled rates established, comparable rates and allowed amounts for similar services in other Medicaid agencies, Medicaid health plans, and commercial insurers were obtained to provide support for the bundled rates developed.

The bundled service procedure codes and its successor codes may be subject to change in the future due to unit measurement conversions and/or elimination/replacement of procedure codes. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The agency's fee schedule rate was set as of February 1, 2013 and is effective for services provided on or after that date. All rates are published at the following SCDHHS website address: https://www.scdhhs.gov/resource/fee-schedules .

In order for the Medicaid Agency to monitor the adequacy of and/or update the bundled rates for future reimbursement periods, the providers of bundled services will be required to maintain the following data:

- The utilization of the individual covered services included in the bundled payment by practitioner and;
- The cost by practitioner and type of service delivered under the bundled rate.

In order to price the cost of each type of service by practitioner, the provider has the option to use the SC Medicaid discrete service rates if actual cost of each service provided under the bundled rate by practitioner is unavailable.

Providers will be required to report this data on an annual basis.

Discrete Rehabilitative Services-Substance Abuse and Addictive Disorders

As a result of the SC Medicaid Agency's decision to bundle certain discrete services into bundled rehabilitative service rates effective February 1, 2013, the rehabilitative fee schedule rates currently in effect for all rehabilitative providers were reevaluated, resulting in the following discrete rehabilitative service rates:

Description	Procedure Code	Description	Procedure Code
Psychiatric Diagnostic Evaluation with Medical Services	90792	Group Psychotherapy	90853
Psychological Testing Diagnostic Assessment Face to Face –	96101	Alcohol and Drug/Substance Abuse Counseling -Individual	H0004
Psychological Testing Diagnostic Assessment Face to Face – administering test and preparing report	96102	Alcohol and Drug/Substance Abuse Counseling - Group	H0005
Alcohol and Drug Assessment – Initial - w/o Physical	H0001	Medication Management	H0034
Alcohol and Drug Assessment – Follow-up - w/o Physical	H0001/TS	Crisis Management	H2011
Alcohol and Drug - Nursing Services	H0001/U2	Family Support	S9482
Alcohol and /or Substance Abuse Structured screening and brief intervention services	99408	Peer Support Service	H0038
Mental Health Service Plan Development by Non-Physician w/Client	H0032-HF	Psychosocial Rehabilitation Service	H2017

Description	Procedure Code	Description	Procedure Code
Mental Health Service Plan Development by Non-Physician w/o Client	H0032	Skills Training and Development Service –	H2014
Individual Psychotherapy Face to Face – 30 minutes	90832	Medication Administration	96372
Individual Psychotherapy Face to Face – 45 minutes	90834	Vivitrol Injection	J2315
Individual Psychotherapy Face to Face – 60 Minutes or more	90837	Family Psychotherapy (without patient present) – Hour session	90846
Individual Psychotherapy Face to Face – 30 minutes with Medical evaluation and management services	90833	Family Psychotherapy (with patient present) – Hour session	90847
Individual Psychotherapy Face to Face – 45 minutes with Medical evaluation and management services	90836	Multiple Family Group Psychotherapy	90849
Medical Evaluation and Management for a New Patient – 30 minute session	99203		
Medical Evaluation and Management for an Established Patient – 15 minute session	99213		

The discrete service rates listed above were developed by taking into consideration the following factors:

- The rehabilitative fee schedule rates currently in effect for all rehabilitative providers were reviewed against Commercial, State Medicaid, and Medicare benchmarks. If the current rehab service rate in effect for all other behavioral health rehabilitative providers was below or reasonable relative to the benchmarks, there was no change to the rehabilitative service rate.

- If a rehabilitative service is a Medicare covered service, in some cases the rehabilitative service rate was adjusted to reflect the equivalent of 77% of the Medicare Fee schedule, which is consistent with many SC Medicaid medical services fee schedule amounts.

- To adjust for different credentialing of the rendering providers, the rehabilitative service rates were adjusted by using salary differentials from SC reported by the Bureau of Labor Statistics.

- To adjust for a service moving from a time unit to an encounter, the rehabilitative service rates were adjusted based on the number of units generally billed for an encounter.

The discrete service procedure codes and its successor codes may be subject to change in the future due to unit measurement conversions and/or elimination/replacement of procedure codes. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The agency's fee schedule rate was set as of February 1, 2013 and is effective for services provided on or after that date. All rates are published at the following SCDHHS website address: https://www.scdhhs.gov/resource/fee-schedules .

17. Nurse Midwife Services:

Nurse Midwife Services are reimbursed at 100% of the Physician Services fee schedule rates effective for services provided on or after the implementation date as outlined in Physician Services methodology located at Attachment 4.19-B, Page 2a.2 Section 5. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers. The agency's fee schedule rate was set as of July 11, 2011 and is effective for services provided on or after that date. All rates are published on the agency's website at www.scdhhs.gov.

18. Hospice Services:

A. Payment Methodology

With the exception of payment for physician services, reimbursement for hospice services is made for one of the five levels of hospice services for each day in which an individual is under the care of the hospice provider:

(1) Routine Home Care of which there are two rates based upon the length of service-(a) Routine Home Care Days 1-60 and (b) Routine Home Care Days 61 and above.

(2) Continuous Home Care

(3) Inpatient Respite Care

(4) General Inpatient Care

(5) Service Intensity Add-On when the following criteria are met:

a) The day on which the services are provided is a Routine Home level of care; and

b) The day on which the service is provided occurs during the last seven days of life and the client is discharged deceased; and

c) The service is provided by a registered nurse or social worker that day for at least fifteen minutes and up to four hours total; and

d) The service is not provided by a social worker via telephone.

Billing instructions relating to the provision of each Hospice service described above are available via the SC Medicaid Hospice Provider Manual. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers. All rates are published on the agency's website at www.scdhhs.gov.

The Medicaid Agency will employ the use of the Medicaid Hospice payment rates published annually via the Centers for Medicare and Medicaid Services' (CMS) Medicaid Financial Management Group. The wage component of the daily hospice rates will be adjusted annually by the applicable annual Medicare Final Hospice Wage Index to reflect local geographical differences in the wage levels. Two sets of Medicaid Hospice payment rates will be established for each of the five hospice service rates to account for the hospice providers' compliance with the Medicare quality reporting requirements authorized under section 3004 of the Affordable Care Act. Failure by a Hospice provider to comply with the Medicare quality reporting requirements during each fiscal year will result in a two percent (2%) rate reduction applied prospectively to the following hospice rate year.

B. Cap on Overall Hospice Payment

The Medicaid Agency will limit overall aggregate payments made to each hospice during a hospice rate year using the following hospice cap periods:

Hospice Rate Year	Hospice Cap Period
2016	Jan. 1, 2016 – Oct. 31, 2016
2017	Nov. 1, 2016 – Oct. 31, 2017
2018	Nov. 1, 2017 – Oct. 31, 2018
2019 and After	Oct 1st – Sept. 30th

The total payment made for hospice services provided to Medicaid beneficiaries during the cap period will be compared to the cap amount applicable to the cap period as published by CMS. The hospice provider must refund any payments in excess of the cap. The hospice payment amount will be determined using dates of services for services provided during the year regardless of when the payment is actually made. For new hospice providers entering the Medicaid program after January 1, 2016, the initial cap calculation for newly certified hospice providers must cover a period of at least twelve (12) months but no more than twenty-three (23) months.

C. Limitations on Inpatient Care

Payments to a hospice for short-term inpatient care provided in a participating hospice inpatient unit, a participating hospital, or a nursing facility that additionally meets the special hospice standards regarding staffing and patient areas are subject to this limitation. Services provided in an inpatient setting must conform to the written plan of care. General inpatient care may be required for procedures necessary for pain control or acute or chronic symptom management which cannot be provided in other settings. Inpatient care may also be furnished to provide respite for the individual's family or other persons caring for the individual at home. Payments to a hospice for inpatient care must be limited according to the number of days of inpatient care furnished to Medicaid patients. During the 12 month period beginning November 1st of each year and ending October 31st, the aggregate number of the inpatient days (both for general inpatient care and inpatient respite care) may not exceed twenty (20) percent of the aggregate total number of days hospice care provided to all Medicaid recipients during that same period. The limitation calculation is determined in accordance with the requirements of 42 CFR 418.302(f).

D. Medicaid Recipients Receiving Hospice Services in Nursing Facilities

In addition to the five reimbursement rates of the services described in section 18(A), Hospice providers are also required to reimburse nursing facilities and Intermediate Care Facilities for individuals with Intellectual Disabilities (ICF/IID) for the Hospice Room and Board per diem. The Hospice Agency will bill Medicaid for the room and board provided to Medicaid beneficiaries who elect hospice and who continue to reside in nursing facilities or ICF/IIDs. Effective for room and board services provided on and after October 1, 2008, the Hospice Agency will receive 98% of the Medicaid nursing facility per diem rate. Effective for services provided on and after July 11, 2011, the Hospice Agency will receive 95% of the Medicaid nursing facility per diem rate. Upon receipt of the Medicaid reimbursement, the Hospice Agencies will reimburse the facility in which the Medicaid beneficiary resides.

Physician Services

Reimbursement will be made to the hospice in accordance with the usual Medicaid reimbursement for physician services when these services are provided by hospice employees or physicians under agreement with the hospice. This reimbursement is in addition to the daily rate. Services furnished voluntarily by physicians are not reimbursable.

Consultant specialty services, when necessary for the palliative care and management of the terminal illness (e.g., radiation for pain relief), are covered separately and are reimbursed only to the elected hospice.

Services of the patient's attending physician, if he or she is not an employee of the hospice or providing services under arrangements with the hospice, are not considered covered hospice services. These services are to be reimbursed directly to the provider physician. The hospice must notify the S. C. Department of Health & Human Services of the name of the physician who has been designated as the attending physician.

19. Targeted Case Management (TCM) services are provided to Medicaid eligible recipients determined to meet the criteria of the following: Individuals with Intellectual and Related Disabilities, At Risk Children, Adults with Serious and Persistent Mental Illness, At Risk Pregnant Women and Infants, Individuals with Psychoactive Substance Disorder, Individuals at Risk for Genetic Disorders, Individuals with Head and Spinal Cord Injuries and Similar Disabilities, Individuals with Sensory Impairments, and Adults with Functional Impairments. These criteria are located in Supplement 1 to Attachment 3.1-A.

The specific targeted case management services to be provided under this section of the state plan are as follows:

1) Comprehensive assessment and reassessment,
2) Development and revision of care plan,
3) Referral activities,
4) Monitoring and follow-up.

TCM for the above populations can be provided by governmental or private providers. In order to develop the Medicaid payment rate, the Medicaid Agency employed the following reimbursement methodology:

1. Personnel Costs:

Governmental Providers: We obtained, from the eight state agencies that provide targeted case management for their populations, the personnel classifications (from the South Carolina Office of Human Resources (SCOHR) Classifications Manual) of the case managers and their supervisors employed in their agency. We obtained from the South Carolina Office of Human Resources, effective July 2011, the compensation ranges, specifically the salary midpoint, for each classification title reported by these agencies as performing case manager or case management supervision services.

Private Providers: We obtained from the May 2010 "OES State Occupational Employment and Wage Estimate" classification titles (and average salaries) that were similar in description to those titles used by governmental providers for case managers.

The average salary data per classification title for the private provider's noted above along with the salary midrange per classification title for the governmental providers were averaged to obtain the base annual salary cost recognized in the determination of an hourly rate for TCM services.

1a Programmatic Supervision – The determination of the allowable programmatic supervision salary add-on is calculated as follows:

1) the annual salary midpoint for each classification title reported by the governmental providers as case management supervisors were averaged to obtain the base annual salary cost recognized for case management supervision,

2) the average annual salary cost per supervisor is multiplied by the estimated percentage of time case manager supervisors spend on programmatic supervision activities per supervised employee (i.e. allocable portion of annual salary for each case manager),

1b. The allocable portion of the annual average salary for the case manager supervisor is added to the average annual salary for the case manager to determine allowable TCM salary costs.

1c. Allowable annual TCM salary costs, as determined in 1b above, are multiplied by the fringe benefit rate for SC state government employees to determine total personnel costs associated with the TCM services.

2. **Other direct operating costs.** Other costs that can be directly assigned to the TCM service are added. These include:

2a. Supplies - Material and supply costs that are required for direct services to clients.

The overriding principle regarding this cost is that the materials or supplies are required or used by the direct (i.e. hands on) provider of service during the course of treatment or provision of care to the Medicaid recipient.

The following characteristics determine the charging of supplies to a medical service or case management:

b) commonly provided in the course of care/treatment by the practitioner or case manager without additional charge,
c) provided as incidental, but integral to the practitioners' or case managers' services, and
d) used by the "hands-on" medical provider or case manager.

2b. Travel/transportation costs – The travel expenses associated with

state plan required visits to the client's home or client's place of residence as defined in the SCDHHS TCM Provider Manual.

3. Indirect costs – Indirect costs (those supporting costs that cannot be directly attributed to the service but rather apportioned over all benefitting programs/services) are recognized by the application of a 10% IDC rate as applied to personnel costs net of fringe benefits.

Determination of Targeted Case Management Rates:

The additional time required to travel to the homes of clients (or other place of residence) for face to face meetings reduces the productivity of the case worker and increases costs for travel. Therefore, two rates have been determined. One which recognizes the loss of productivity and the

increased cost related to travel when meeting the client and family in their home or other place of residence. The other reduced rate recognizes the increased level of productivity and reduced costs for case management services that are primarily rendered within the offices of the provider.

"Home/Residential Contact" Case Management Rate:

The composition and determination of the "Home/Residential Contact" (as defined in the MTCM Provider Manual) CM rate is as follows:

a) personnel costs, salaries and fringe benefits, for the case manager and programmatic case manager supervisor as defined and developed in section 1 above,

b) direct supply costs as defined in section 2,

c) travel costs, (estimated annual mileage for required in home or place of residence visits X estimated unique client visits per year X Federal mileage rate),

d) indirect costs, the indirect cost rate applied as indicated in section 3 above.

The sum of the costs above represents the annual cost of "Home/Residential Contact" TCM services for one case manager. This result is divided by annual "productive hours" as determined by a productivity factor to determine an hourly TCM rate. The hourly rate is divided by four to produce a fifteen minute billing rate for "Home/Residential Contact" TCM services.

"Office Contact" Case Management Rate

The composition and determination of the "Office Contact" (as defined in the MTCM Provider Manual) TCM rate is as follows:

e) personnel costs, salaries and fringe benefits, for the case manager and programmatic case manager supervisor as defined and developed in section 1 above,

f) direct supply costs as defined in section 2,

g) indirect costs, the indirect cost rate applied as indicated in section 3 above.

The sum of the costs above represents the annual cost of "Office Contact" TCM services for one case manager. This result is divided by annual "productive hours" as determined by a productivity factor to determine an hourly TCM rate. The hourly rate is divided by four to produce a fifteen minute billing rate for "Office Contact" TCM services.

Transition Rates

The rates above represent market based, industry wide rates reimbursable to both governmental and private providers of TCM services.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Targeted Case Management (TCM) services. The agency's fee schedule rate was set as of January 1, 2013 and is effective for services provided on or after that date. All rates are published on the agency's website at www.scdhhs.gov. However, for governmental providers of TCM services, a "phase in" period will be allowed to provide a transition from previous retrospective cost-based reimbursement to the market based rates. Reimbursement during the "phase in" period will be as follows:

1. Effective January 1, 2013 , the governmental provider will receive rates based on: 75% of their cost based rate from the SFY 2010 cost report (or their most recently filed cost report) and 25% of the market based rates (either "Office Contact" or "Home/Residential Contact") as determined by the methodologies described above.

2. Effective July 1, 2014, the governmental provider will receive rates based on: 50% of their cost based rate from the SFY 2010 cost report (or their most recently filed cost report) and 50% of the market based rates (either "Office Contact" or "Home/Residential Contact") as determined by the methodologies described above.

3. Effective July 1, 2015, the governmental provider will receive rates based on: 25% of their cost based rate from the SFY 2010 cost report (or their most recently filed cost report) and 75% of the market based rates (either "Office Contact" or "Home/Residential Contact") as determined by the methodologies described above.

4. Effective July 1, 2016, the governmental providers will be fully transitioned over to the market based rates, "Office Contact" or "Home/Residential Contact", as determined by the methodologies described above.

5. Private providers of TCM services will receive 100% of the market based rates as determined by the methodologies described above beginning January 1, 2013.

Annual Cost Identification Process for Governmental Providers:

Each governmental provider rendering Targeted Case Management services will be required to submit a CMS approved annual cost report to establish the costs of their services. Allowable costs will be classified as follows and reported separately for "Office Contact" and "Home/Residential Contact" TCM rates:

Direct Costs:

1) Personnel costs – Expenditures from the accounting records for the incurred salaries, payroll taxes, and fringe benefits for the employees providing case management services. For employees who are not assigned to work 100% of their time in TCM services, time sheets will be required to allocate salary, payroll taxes and fringe benefits.

   Only those personnel costs for individuals meeting the requirements of TCM Case Manager will be considered as allowable expenditures for the cost report and reconciliation.

2) Materials and supplies required for the provision of service.

The overriding principle regarding this cost is that the materials or supplies are required or used by the direct (i.e. hands on) provider of service during the course of treatment or provision of care to the Medicaid recipient.

The following characteristics determine the charging of supplies to a medical service or case management:

a) commonly provided in the course of care/treatment by the practitioner or case manager without additional charge,

b) provided as incidental, but integral to the practitioners' or case managers' services, and used by the "hands-on" medical provider or case manager.

3) Travel/transportation costs represent the travel expenses associated with visits to the client's home or place of residence for assessment(s) and monitoring.

The governmental providers of this service will report the actual travel/transportation cost incurred by case managers in the provision of case management services as identified through their accounting system. Examples of allowable expenditures include documented mileage paid to case managers for the use of their private vehicles and directly charged and documented expenses of the state providers' fleet vehicles used by case managers.

4) Any other direct costs not noted above but directly assignable, excluding subcontract arrangements for direct service delivery and costs included in indirect cost determination.

Supervision:

Costs of programmatic supervision will be added to the direct costs associated with the case managers. Allowability of supervisory costs is determined based on time and effort reports which will identify and separate administrative activities of the supervisor versus those activities that are programmatic in nature (i.e. participating in assessment and care plan meetings, participation in follow-up and re-evaluation activities, review and evaluation of case management documentation). Time and effort reports completed in accordance with 45 CFR Part 75 and 42 CFR Part 413 will be used to determine programmatic supervision costs.

Indirect Costs:

Allowable indirect costs can be determined in one of two ways:

- Allowable indirect costs can be determined by the application of the provider's federally approved indirect cost rate or federally approved cost allocation plan or

- An allocation of administrative/overhead costs as allowed in accordance with 45 CFR Part 75 and 42 CFR Part 413. This option will only be available for those state agencies that provide institutional or acute care services.

Total Allowable Costs of Targeted Case Management Services:

The allowable costs for targeted case management services will be the sum of allowable direct costs, programmatic supervisory costs as applicable, and indirect costs as determined above.

Service Statistics:

All governmental providers will be required to accumulate and report service utilization statistics (i.e. units of service) for the total universe of service recipients in keeping with the accumulation of costs by total population of users. The unit measure for this service for all providers, private and governmental, is fifteen (15) minutes.

Comparison of Allowable Medicaid Reimbursable Costs to Interim Payments:

The governmental providers of this service will submit a cost report within 120 days after the close of their fiscal year. Annual cost reports will be desk reviewed for accuracy and compliance with 45 CFR Part 75 and 42 CFR Part 413. The result of total allowable costs divided by total units of service produce the average allowable unit rate.

For governmental providers that use certified public expenditures as the source of state matching funds, the average allowable unit rate multiplied by Medicaid units of service (as determined by the SCDHHS MMIS) becomes annual allowable Medicaid cost for the governmental provider. This amount is compared to Medicaid interim payments (including TPL) and any prior adjustments and/or recoupments for these services. Any interim payments in excess of annual allowable Medicaid cost will be recouped from the governmental provider. Should interim payments fall below the annual allowable Medicaid cost no payment will be made to the provider.

19. b. **Payment for Tuberculosis (TB) related services under section 1902z)(2)(F) of the Act**

TB related services are covered on or after November 4, 2014.

- Reimbursement for Physician Services, Laboratory and X-Ray Services will be according to an established fee schedule based on the methodology outlined in the Physician Services section 5 of Attachment 4.19-B. The Physician Services fee schedule rates are effective for services provided on or after the implementation date as outlined in the Physician Services section 5 of Attachment 4.19-B.

- Reimbursement for Outpatient Hospitals will be according to the established methodology outlined in the Outpatient Hospital Services section 2.a.of Attachment 4.19-B and are effective for services provided on or after implementation date as outlined in the Outpatient Hospital Services section of Attachment 4.19-B.

- Reimbursement for RHC and FQHC Clinic Services will be according to the established methodology outlined in the RHC and FQHC section 2b. and 2c. of Attachment 4.19-B and are effective for services provided on or after implementation date as outlined in the RHC and FQHC section 2b and 2c of Attachment 4.19-B.

- Reimbursement for Clinic Services will be according to the established methodology outlined in the Clinical Services section 9 of Attachment 4.19-B and are effective for services provided on or after implementation date as outlined in the Clinical Services section 9 of Attachment 4.19-B.

- Reimbursement for Pharmacy Services will follow the methodology outlined in the Prescribed Drugs section 12.a. of Attachment 4.19-B. Drugs prescribed to treat TB are exempt from cost sharing.

Medicaid Bulletins informing the providers of the fee schedule rate changes, as well as the fee schedule itself, are available on the agency's web site at http://www.scdhhs.gov/ServiceProviders/FeeSchedules.asp.

20.a &
20 b Extended pregnancy related services are reimbursed individually based upon the methodologies described below under 20.A., 20.B., and 20.C. Services provided by state owned/operated entities will not exceed cost.

A. Risk Assessment – Risk assessments as defined in Attachment 3.1-A must be provided by a physician, registered nurse, or licensed practical nurse utilizing the policies and procedures outlined in the SCDHHS Medicaid Enhanced Services Manual and the SCDHHS Physicians, Laboratories, and Other Medical Professionals Manual. These services are reimbursed utilizing procedure code 99420, Administration and Interpretation of Health Risk Instrument. These services are provided by state owned and private providers. In order to price the assessments, the Medicaid Agency has limited its reimbursement to no more than the amount reimbursed by Medicare via CPT code 99211. CPT code 99211 is used because it most closely mirrors the amount of effort required to perform the risk assessments as described in Attachment 3.1-A. No cost reports are required nor any cost settlements made to the state owned providers of service.

B. Healthy Mothers/Healthy Futures Program – These are enhanced educational and referral services as described in Attachment 3.1-A that are available to pregnant women and newborns. These services are rendered by primary care providers utilizing the policies and procedures outlined in the SCDHHS Physicians, Laboratories and Other Medical Professionals Manual and are provided coincident with the initial OB or subsequent antepartum or newborn visits. Payment rates have been established to reimburse primary care providers for the following enhanced services:

99203 Initial OB Exam with Additional Services
99213 Antepartum Visits with Additional Services
97802 Newborn Care Exam with Additional Services

The reimbursement rates for these services are established at percentages up to 100% of the Medicare fee schedule for the corresponding CPT codes. The reimbursement rates for services to pregnant women (99203 and 99213) are inclusive of <u>all</u> services received during the initial and antepartum visits. The reimbursement rate established for services to the newborn are in addition to the payment made for the medical services rendered during the visit. The additional payment (97802) is to cover the additional educational and referral activities. No cost reports are required nor any cost settlements made to the state owned providers of service.

C. Postpartum/Infant Home Visits – Postpartum/Infant Home Visits as defined in Attachment 3.1-A are services provided in the recipient's home to a mother and infant, by a registered nurse in conformity to standards outlined in the SCDHHS Medicaid Enhanced Services Manual and the SCDHHS Physicians, Laboratories, and Other Medical Professionals Manual. The following services, provided by public and private

providers, are reimbursed by Medicaid as Postpartum/Infant Home Visits:

99501 (00) Postpartum/Infant Home Visit
99501 (52) Postpartum/Infant Home Visit, Repeat Visit
T1028 (HA) Pre-Discharge Home Visit

1. The reimbursement rate for the Postpartum/Infant Home Visit, Procedure Code 99501 (00), rendered by the public and private providers has been established at the same rate reimbursed to South Carolina's State Health Agency for a Skilled Nursing Home Health visit. This rate was chosen due to the comparability of resources used and services provided.

   The methodology employed to reimburse Skilled Nursing Home Health services limits reimbursement to the lesser of allowable Medicare costs, provider's charges or established Medicare cost limits. This methodology was established upon implementation of South Carolina's Medicaid Home Health Program and was designed to emulate the Medicare Home Health methodology in place at that time. This methodology is described at Attachment 4.19-B, 7A (page 3). When Medicare implemented PPS on October 1, 2000, the South Carolina Medicaid Program retained all elements of the prior Medicare methodology with the exception of freezing the Medicare cost limits per discipline to those published in the Federal Register dated August 5, 1999. Annually, South Carolina requires the submission of CMS 1728-94, the Medicare cost report format for Home Health providers. This report is desk reviewed, the comparison of allowable Medicare costs, provider charges and Medicare cost limits made, and a resulting cost settlement is processed.

   In the application of the Home Health methodology to the derivation of Postpartum/Infant Initial Home Visit rate, the State Health Agency's Skilled Nursing service rate has become the Medicare limit as published in the August 5, 1999 Federal Register, i.e. the reimbursable Skilled Nursing Home Health rate for the State Health agency.

2. The reimbursement rate for the Postpartum/Infant Home Visit, Repeat Visit, Procedure Code 99501 (52), rendered by public and private providers is reimbursed as a percentage of the Postpartum/Infant Home Visit. The personnel required to provide the service and the characteristics of service delivery are effectively the same. The differentiating features are the focus of the visit and the length of time required to perform the service. The reimbursement rate for the Repeat Visit is 38% of the Initial Postpartum/Infant Home Visit rate.

3. The reimbursement rate for the Pre-Discharge Home Visit, Procedure Code T1028 (00), rendered by public and private providers is reimbursed as a percentage of the Postpartum/Infant Home Visit. The personnel required to provide the service and the characteristics of service delivery are effectively the same. The

differentiating features are the focus of the visit and the length of time required to perform the service. The reimbursement rate for the Pre-Discharge Home Visit is 50% of the Initial Postpartum/Infant Home Visit rate.

No cost reports are required nor any cost settlements made to the state owned providers of postpartum/infant home visit services.

D. Reimbursement for Enhanced Services to non-high risk pregnant women as described in Attachment 3.1-A were discontinued on October 1, 1996.

24.a Transportation:

A. Broker Transportation Services: See Supplement 2 to Attachment 3.1-A.

B. Non-Broker Transportation Services:

Emergency Ambulance Services: Payment for emergency ambulance services will be the lesser of actual charges submitted by the carrier or the ceiling of the fees established by SCDHHS and published in the Ambulance Services Provider Manual. The fee schedule for ambulance services is inclusive of all supplies required during transportation to include EKG/DEF, airways, oxygen, and field drugs. The fee schedule will be applied uniformly without consideration of locality. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers. For the covered Medicaid emergency ambulance services that have a comparable Medicare rate, the Medicaid fee payments will not exceed the payments calculated at one hundred percent of the Medicare Fee Schedule (in the aggregate). The agency's fee schedule rate was set as of October 1, 2016 and is effective for services provided on or after that date. All rates are published on the agency's website at www.scdhhs.gov.

Special Needs Transportation:

Special Needs Transportation (SNT), as defined on page 9d of Attachment 3.1-A, Limitation Supplement is reimbursed based on a statewide route rate per child. Effective October 1, 2012, the public provider of this service, the State Department of Education (SDE), will be reimbursed a prospective route rate based upon its FY 2010 annual Medicaid cost report.

Description and Discussion of Cost Finding for SNT:

South Carolina is unique in that the state agency, SDE, and local school districts each contribute to the provision of school based transportation services in the state. The SDE maintains and fuels the buses and bus "shops", assists with routing, enforces state school bus policies, and trains district drivers. School bus drivers are employees of their local school districts. Each school district also employs staff to coordinate and schedule routes for that district.

Prior to billing for SNT services for a Medicaid recipient, the districts must ensure that a Medicaid service as specified in the Medicaid's recipient's IEP or IFSP was provided and billed on the date of the Special Needs Transportation service. Only transportation services provided in a Special Needs bus (i.e. buses specifically adapted to serve the needs of the disabled) are eligible for reimbursement.

The October 1, 2012 rate development and cost finding methods for Special Needs Transportation are summarized below and will be based on the July 1, 2009 through June 30, 2010 Special Needs Transportation Medicaid cost report.

School Districts' Direct Costs:

1. The school districts' costs associated with state mandated student transportation is determined for all participating districts. The local school districts' accounting structure is established to isolate the direct costs of state mandated student transportation to include salaries and fringes of school bus drivers, schedulers and coordinators and districts' expenses such as supplies and purchased services for that function.

   There is applied to each individual school district's costs described above, the district's specific indirect rate as calculated by the SDE in cooperation with the United States Department of Education. The result represents the indirect support provided in each district for student transportation services.

   Costs of the participating districts are accumulated (net of equipment allowances) for the determination of the statewide rate.

State Department of Education (SDE) Direct Costs:

1. The costs incurred by the SDE related to the purchase and maintenance of equipment for statewide student transportation are identified. Costs included here include maintenance salaries and fringes, supplies, purchased services and other expenses associated with maintaining the statewide fleet of buses. This includes all costs associated with the operation of 44 bus shops statewide to include fuel purchases, parts and repairs, shop supplies, and insurance.
2. The costs incurred by the SDE, Office of Transportation, for the administration of the student transportation are identified. These costs are incurred for assistance with district routing, enforcement of state school bus policies, training of district drivers, and management of statewide operations. Costs included here include salaries and fringes, supplies, purchased services associated with student transportation administration.
3. State Department of Education costs as defined above are accumulated (net of allowances for capital items) for the determination of the statewide rate. The SDE's indirect cost rate is applied to reflect the indirect support of SDE provided to the Office of Transportation services.

Application of Use Allowances for Capital Items:

Use allowances for SDE and the local school districts' equipment items are determined in accordance with the use allowance provisions and policies under 45 CFR Part 75 and 42 CFR Part 413. Use allowances are determined for: 1) SDE's bus shop buildings and equipment and 2) the local school districts' equipment items used in the provision of transportation services. Special needs bus allowances will be addressed below at Distribution of Cost Pool, Item 3.

Total Transportation Cost Pool:

The total statewide Transportation Cost Pool is comprised of school district level accumulated costs, SDE identified student transportation costs, indirect costs and use allowances for related equipment of both SDE and the local school districts as described above.

Distribution of Cost Pool:

Since the cost pool accumulated above is based on statewide student transportation services, special needs transportation services must be carved out of statewide services.

1. Total Special Needs Mileage is accumulated for all Special Needs routes in participating school districts. Total Student Transportation Mileage is accumulated for all participating school districts. The percentage of special needs mileage to total student transportation mileage is determined.

2. The resulting Special Needs percentage is applied to the Total Transportation cost pool to determine Special Needs transportation costs.

3. A use allowance for Special Needs buses (i.e. buses specially adapted to serve the needs of disabled students), based on SDE inventory records, is determined in accordance with the use allowance provisions and policies under 45 CFR Part 75 and 42 CFR Part 413. This use allowance is added to previously determined Special Needs Transportation costs (item 2 above) to determine the Total Special Needs Transportation Cost Pool.

Utilization Data and Determination of Special Needs Route Rate:

1. A determination of the total number of enrolled Special Needs students' routes per student per day per school year is calculated. (This number is determined by multiplying all Special Needs Student routes run daily per student by the number of school days in the school year.)

   Note: A route is defined as a one-way "trip" (ex. home to school, school to home, school to Medicaid service).

2. This utilization of Special Needs bus services is divided into the Special Needs Transportation Costs Pool to determine the Cost per Special Needs Student per route rate prior to the application of a trend factor.

Determination of the Prospective Special Needs Transportation Route Rate Effective October 1, 2012

In order to establish the October 1, 2012 Special Needs Transportation Route Rate effective October 1, 2012, the agency employed the use of the midpoint to midpoint methodology using an annual trend rate of two percent (2%).

The retrospective cost settlement process previously utilized will no longer be employed.

Other Types of Transport Services (Non-Brokered):

Targeted Populations: Other types of transports are provided to targeted Medicaid populations to Medicaid covered services. These services are provided to Medicaid children who may require non-parental escort to Medicaid services. These services are provided by:

1) State agencies,
2) Local Education agencies (LEAs).

The mode of transportation for services provided by the Local Education Agencies is either school buses or mini-vans. In the instances of LEAs utilizing school buses, these buses transport groups of Medicaid eligible children from home or district schools to covered Medicaid services provided by the district (i.e. Rehabilitative behavioral health services.) These buses are not specially modified buses for the physically handicapped (i.e. Special Needs Transportation).

Annually, all providers of NET services submit for approval budgets for their upcoming rate cycles. Rates are determined on a per passenger mile basis. Provider budgets, completed on the SCDHHS preprint budget, are comprised of:

State Agency and School District Providers:

1. **Direct costs:** Salaries and fringe benefits of drivers and escorts, vehicle fuel, repairs and maintenance. Also, insurance, taxes, licenses and registration, and/or any associated vehicle leases.

Depreciation is allowed on provider owned vehicles. A state agency or school based provider may allocate costs of fleet operations if applicable.

2. **Indirect costs:** To provide for the administrative and overhead costs the provider incurred to support the Medicaid Transportation contract, the provider is allowed to apply their specific indirect rate. For state agency providers, this will be the indirect rate as approved by USDHHS. For local school districts, this will be the unrestricted indirect rate as calculated by the SDE in cooperation with the United States Department of Education.

3. **Service Utilization Statistics:** Service units are passenger miles. As cost is based on services provided to all passengers (i.e. total passengers), annual units of service projections are based on total passenger miles.

Annual Cost Reports (State Agency and School Based):

Annual cost reports are required of all state agency providers of non-emergency transportation services described above to ensure that these providers have not received reimbursements in excess of actual allowable costs.

For all state agency providers of non-emergency transportation, the budgeted rate established at the beginning of the contract year represents their maximum per passenger mile reimbursement rate for the year. Cost reconciliation based on the annual cost reports of public providers is completed. If a state agency provider's interim payments exceed the actual allowable costs of non-emergency transportation services, the SCDHHS will establish a receivable to recover the excess payments. No additional payments will be made to a provider as a result of the cost reconciliation process.

For Local Education Agencies also participating in the Administrative Claiming program, services associated with coordinating and scheduling of transportation services are specifically excluded from allowable Administrative Claiming activities.

28(i) Licensed or Otherwise State-Approved Freestanding Birth Centers: For services provided at a birthing center, the facility payment will be no more than 50 percent of a normal vaginal hospital delivery. The provider shall append a TC modifier to the vaginal delivery code when billing the all-inclusive facility fee. The Licensed or Otherwise State Approved Freestanding Birth Centers facility fee schedule rate is effective for services provided on or after the implementation date as outlined in the Physician Section 5, Attachment 4.19-B, Page 2a.2.

28(ii) Licensed or otherwise State-Recognized covered professionals providing services in the Freestanding Birthing Center: Reimbursement for midwifery services for a normal vaginal birth are based on the lesser of billed charges, or 100% of the allowed provider reimbursement for a routine delivery*.

All other obstetrical services provided by midwives are reimbursed at the allowed provider reimbursement (*) based on South Carolina's Physician Fee Schedule.

* Allowed provider reimbursement is based on provider type, i.e. certified nurse midwive or licensed midwife. A certified nurse midwife receives 100% of the allowable reimbursement based on the South Carolina Physician's Fee Schedule while a licensed midwife receives 65 percent of the allowable reimbursement.

Program of all-Inclusive Care for the Elderly (PACE):

A. PACE Upper Limit Calculation:

1. Data is summarized from the FFS experience for individuals ages 55 and over who are nursing home eligible into the following populations:

   a. Dual eligible community residents enrolled in the CLTC waiver

   b. Medicaid only community resident enrolled in the CLTC waiver

   c. Dual eligible nursing home residents

   d. Medicaid only nursing home residents

Fee-for-service (FFS) experience is summarized by eligibility category and covered service category.

CLTC waiver services were included in the following service categories:

- Personal Care Services
- Attendant Care Services
- Adult Day Care Services
- Homemaker Services
- Home Meal Delivery

2. Adjustments are applied to reflect the contract period for each population.

In this step, adjustment factors are applied to reflect the differences between the base experience period and the MCO contract period.
IBNR Adjustment:

The fee-for-service data that is used in developing the Medicaid managed care rates include allowing for nine months of run-out for the base experience period. The Incurred, But Not Reported (IBNR) adjustment reflects an estimate of the claims that will be paid after the last payment dates incurred claims.

Reimbursement Adjustments:

Adjustments are made to reflect the difference in fee schedules between the base experience period and the contract period.

Trends:

Trend rates are derived from SCDHHS quarterly budget projections

Third Party Liability Adjustment:

A factor is used to adjust for third party liability (TPL) recoveries that are not included in the claims data for the Medicaid Only population.

Non-Emergency Transportation Add-On:

The base experience data does not include the cost of non-emergency transportation services provided by South Carolina's non-emergency transportation contractor. To account for this missing cost, a non-emergency transportation add-on is included in the PACE rate development.

3. Blend the Community and Nursing Home resident populations to develop the PACE UPL.

In this step, the projected cost for the community and nursing home resident population is blended for each eligibility group. The resulting blended cost is the PACE UPL for the contract period.

4. Calculate Capitation Rates

To calculate the PACE capitation rates, the projected cost for the community and nursing home resident population is blended for each eligibility group net of patient liability.

Then, an added allocation is given for patient liability consistent with the proportion of PACE enrollees that are expected to reside in a nursing home and pay the patient liability.

The base capitation rates for South Carolina PACE are set at 96 percent of the UPL net of patient liability.

implemented during or after the claim reporting period but prior to the effective date of the rate period. Additionally, the South Carolina Department of Health and Human Services (SCDHHS) reserves the right to adjust the initial PACE Medicaid rate in the event of Medicaid policy changes during the course of the PACE rate period, subject to prior approval by the CMS regional office.

2. Medicaid service cost expenditures as determined in (3) above will be accumulated separately for eligibles residing in nursing facilities and eligibles participating in the CLTC program. Additionally, member months as determined in (2) above will be accumulated separately for eligibles residing in nursing facilities and eligibles participating in the CLTC program. Total Medicaid service costs for each group (i.e., nursing home residents and CLTC participants) will be divided by total member months for each group to determine an average nursing home member month cost and an average CLTC member month cost. This calculation will be performed separately for Medicaid eligibles and dual eligibles.

3. In order to calculate the upper payment limit for PACE participants, an adjustment for patient acuity must be made. Therefore, the average nursing home member month cost and the average CLTC member month cost as determined in (4) above will be weighted to determine the upper payment limit for PACE participants.

B. PACE Medicaid Rate Calculation:

The Medicaid rate for PACE participants will represent no more than 100% of the weighted UPL as determined in (5) above. Separate rates will be established for Medicaid eligibles and dual eligibles.

13c Preventive Services continued:

Diabetes Management

A diabetes management program, as defined in Attachment 3.1-A, Limitation Supplement, Pages 6a.5 and 6a.6 must be managed by a Certified Diabetes Educator and adhere to the National Standards for Diabetes Self-Management Education or be a program recognized by the American Diabetes Association or Indian Health Service. The services are provided in accordance with the policies and procedures outlined in the Diabetes Management Manual.

S0315 Disease management program--Initial Assessment/Initiation of Program
S9445 Patient Education – Patient education, not otherwise classified, non-physician provider, Individual per session
S9455 Diabetic management program – Group session
S0316 Follow-Up/Reassessment

The payment rates for individual and group diabetes disease management were initially established at 80% of the 2005 Medicare Fee Schedule using procedure codes G0108 and G0109 as the basis. Because the two Medicare procedure codes represent a thirty-minute unit and a Medicaid unit of service for diabetes disease management represents a fifteen-minute unit, the individual and group rate are further reduced by fifty percent.

Medicaid codes: S0315, S9445, and S0316
(Medicare code: G0108 - Diabetes outpatient self-management training services, individual)

Medicaid code: S9455
(Medicare code: G0109 - Diabetes outpatient self-management training services, group)

State developed fee schedule rates are the same for both public and private providers. The fee schedule and any annual/periodic adjustments to the fee schedule are published in Medicaid Bulletins and will not exceed 100% of the Medicare fee schedule.

Sickle Cell Disease Management Services

Sickle cell disease management services must be provided by registered nurses, licensed social workers, and/or licensed practical nurses, as defined in Attachment 3.1-A Limitation Supplement pages 6a.6, 6a.7 and 6a.8. The following services will be reimbursed by Medicaid as a sickle cell disease management service:

(A) – Initial Assessment and Initiation of the Program provided by registered nurses, licensed social workers and/or licensed practical nurses (unit of service – 15 minutes) procedure code S0315;

(B) – Follow up Reassessment provided by registered nurses, licensed social workers, and/or licensed practical nurses(unit of service – 15 minutes) procedure code S0316;

(C) – Patient Education Non Physician Provided – Individual provided by registered nurses, licensed social workers, and/or licensed practical nurses(unit of service – per session) procedure code S9445);

(D) – Patient Education Non Physician Provided – Group provided by registered nurses, licensed social workers, and/or licensed practical nurses (unit of service – per session) procedure code S9446

Effective for services provided on or after May 1, 2014, Medicaid reimbursement rates for sickle cell disease management services will be established at eighty percent (80%) of the 2012 Medicare Physician Fee schedule released January 4, 2012. Both private and governmental providers will receive these rates.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: South Carolina

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

Payment of Medicare Part A, Part B and Part C Deductible/Coinsurance

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Except for a nominal recipient copayment (as specified in Attachment 4.18 of this State plan), if applicable, the Medicaid agency uses the following general method for payment:

1. Payments are limited to State plan rates and payment methodologies for the groups and payments listed below and designated with the letters SP.

   For specific Medicare services which are not otherwise covered by this State plan, the Medicaid agency uses Medicare payment rates unless a special rate or method is set out on Page 3 in item D of this attachment (see 3. below).

2. Payments are up to the full amount of the Medicare rate for the groups and payments listed below, and designated with the letters MR.

3. Payments are up to the amount of a special rate, or according to a special method, described on Page 3 in items A, B and C of this attachment, for those groups and payments listed below and designated with the letters NR.

4. Any exceptions to the general methods used for a particular group or payment are specified on Page 3 in item A of this attachment (see 3. above).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: South Carolina

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Payment of Medicare Part A, Part B and Part C Deductible/Coinsurance

QMBs:	Part A	NR	Deductibles	NR	Coinsurance		
	Part B	NR	Deductibles	NR	Coinsurance		
	Part C	NR	Deductibles	**NR**	**Coinsurance**		
Other Medicaid Recipients	Part A	NR	Deductibles	NR	Coinsurance		
	Part B	NR	Deductibles	NR	Coinsurance		
	Part C	NR	Deductibles			**NR**	**Coinsurance**
Dual Eligible (QMB Plus)	Part A	NR	Deductibles	NR	Coinsurance		
	Part B	NR	Deductibles	NR	Coinsurance		
	Part C	NR	Deductibles			**NR**	**Coinsurance**

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: South Carolina

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Payment of Medicare Part A, Part B and Part C Deductible/Coinsurance

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A. Effective with claims processed on or after August 9, 2011, payment for Medicare Part A coinsurance and deductibles (other than nursing facilities) will be reimbursed as follows:

The Medicaid payment will amount to the Medicaid claim payment less the amount paid by Medicare not to exceed the sum of the Medicare coinsurance and deductible. The Medicaid claim payment amount will be calculated in accordance with Attachment 4.19-A of the South Carolina State Plan.

B. Effective with claims processed on or after August 9, 2011, payment for Medicare Part B coinsurance and deductibles will be reimbursed as follows:

The Medicaid payment will amount to the Medicaid claim payment less the amount paid by Medicare not to exceed the sum of the Medicare coinsurance and deductible.

C. Effective with claims processed on or after August 9, 2011, payment for Medicare Part C coinsurance and deductibles will be reimbursed as follows:

The Medicaid payment will amount to the Medicaid claim payment less the amount paid by Medicare not to exceed the sum of the Medicare coinsurance and deductible (and/or co-payments and deductibles).

D. For services which are covered by Medicare but are not covered by the SC State Plan, the Medicaid claim payment referenced in paragraphs A, B and C above, will be 75% of the Medicare rate for QMB recipients. There will be no payment for non-covered SC State Plan services for non-QMBs. See section 4.19-D of the Medicaid State Plan for the limitation on nursing home coinsurance payments.

State Plan Under Title XIX of the Social Security Act

Medical Assistance Program

State: South Carolina

Citation

42 CFR 447, 434, 438, and 1902(a)(4), 1902(a)(6), and 1903

Payment Adjustment for Provider Preventable Conditions

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4),1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

Health Care-Acquired Conditions

The State identifies the following Health Care-Acquired Conditions for non-payment under Section 4.19 (A)

__X__ Hospital-Acquired Conditions as identified by Medicare other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients.

Effective July 11, 2011, Medicaid will make zero payments to providers for services related to Provider Preventable Conditions (PPC) which includes Healthcare Acquired Conditions (HCAC). Reimbursement for conditions described above is defined in Attachment 4.19-A, Page 26a of this State Plan

State Plan Under Title XIX of the Social Security Act

Medical Assistance Program

State: South Carolina

Citation

42 CFR 447, 434, 438, and 1902(a)(4), 1902(a)(6), and 1903

Payment Adjustment for Provider Preventable Conditions

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4),1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Section(s) Attachment 4.19-B of this State Plan.

__X__ Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.
On and after the above effective date, Medicaid will make zero payments to providers for Other Provider-Preventable Conditions which includes Never Events (NE) as defined by the National Coverage Determination (NCD). The Never Events (NE) as defined in the NCD includes Inpatient Hospitals, Outpatient Hospitals, Ambulatory Surgical Centers (ASC) and practitioners, and these providers will be required to report NEs. Reimbursement for conditions described above will be defined in Attachment 4.19-B, of this State Plan.

Also consistent with the requirements of 42 CFR 447.26(c).

(c)(2) No reduction in payment for a provider preventable condition will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.

(c)(3) Reductions in provider payment may be limited to the extent that the following apply:

i. The identified provider-preventable conditions would otherwise result in an increase in payment.

ii. The State can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the provider-preventable conditions.

(c)(5) Non-payment of provider-preventable conditions shall not prevent access to services for Medicaid beneficiaries.

State Plan Under Title XIX of the Social Security Act

Medical Assistance Program

State: South Carolina

_____ Additional Other Provider Preventable Conditions identified below (please indicate the Section(s) of the plan and specific service type and provider type to which the provisions will be applied.

State Plan Under Title XIX of the Social Security Act

Medical Assistance Program

State: South Carolina

Payment for Other Provider Preventable Conditions to include the three Never Events:

Effective with date of processing October 1, 2012, any claim for dates of service on/after September 7, 2012, and in accordance with Title XIX of the Social Security Act-Sections 1902 (a)(4), 1902(a)(6), and 1903 and 42 CFR's 434.6, 438.6, 447.26, Medicaid will make no payments to providers for services related to Other Provider Preventable Conditions (OPPC's) that at a minimum must include the Never Events (NE)

Never Events will be identified with the following ICD-9 or diagnosis codes or ICD-10 replacement diagnosis codes:

- E876.5-Performance of wrong operation (procedure) on correct patient
- E876.6-Performance of operation (procedure) on patient not scheduled for surgery
- E876.7-Performance of correct operation (procedure) on the wrong side/body part

No reduction in payment for the Other Provider Preventable Condition that include at a minimum the Never Events will be imposed on a provider when the surgery or procedure defined as a Never Event for a particular patient existed prior to the initiation of treatment for the patient by that provider.

Reductions in provider payment may be limited to the extent that the following apply:

1. The State can reasonably isolate for non-payment the portion of the payment directly related to treatment for, and related to, the Other Provider Preventable Condition that include at a minimum the Never Events.

The following method will be used to determine the payment adjustment for Other Provider Preventable Conditions that at a minimum include the Never Events as defined by the National Coverage Determination for dates of services beginning on or after October 1, 2012:

Within thirty days of receiving a paid claim, in the South Carolina Medicaid Information System (MMIS) with a diagnosis code for any of the three Never Events will be reviewed to ensure the State can reasonably isolate for non-payment the portion of the payment directly related to the treatment for, and related to, the Other Provider Preventable Condition that include at a minimum the Never Events.

State Plan Under Title XIX of the Social Security Act

Medical Assistance Program

State: South Carolina

Citation

42 CFR 434.6, 438.6, 447.26 and 1902(a)(4), 1902(a)(6), and 1903 of the Social security Act.

Payment Adjustment for Other Provider Preventable Conditions

The Medicaid agency meets the requirements of 42 CFR Part 447, subpart A, and sections 1902(a)(4), 1902(a)(6), and 1903 with respect to non-payment for other provider preventable conditions.

Other Provider Preventable Conditions

The State identifies the following Other Provider Preventable Conditions for non-payment under Section 4.19(B) of this plan effective for discharges on or after July 1, 2014:

X Wrong Surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

X Post-operative death in normal healthy patient

X Death/disability associated with use of contaminated drugs, devices or biologics

X Death/Disability associated with use of device other than as intended

X Death/disability associated to medication error

X Maternal death/disability with low risk delivery

X Death/disability associated with hypoglycemia

X Death/disability associated with hyperbilirubinemia in neonates

X Death/disability due to wrong oxygen or gas

Effective with date of processing October 1, 2012, any claim for dates of service on/after September 7, 2012 Medicaid will make zero payments to providers for Other Provider Preventable Conditions which

includes Never Events (NE) as defined by the National Coverage Determinations (NCD). The Never Events (NE) as defined in the NCD include Ambulatory Surgical Centers (ASC) and practitioners, and these providers will be required to report NE's. Practitioners are defined in Attachments 4.19 B-Pages 1e, 3a. and 2a.2.

Reimbursement for conditions described above is defined in Attachment 4.19-B, Page 1a.1, of this State Plan.

__ Additional Other Provider Preventable Conditions identified below (please indicate the section(s) of the plan and specific service type and provider type to which the provisions will be applied.)

Citation

42 CFR 447, 434, 438, and 1902(a)(4), 1902(a)(6), and 1903

Payment Adjustment for Provider Preventable Conditions

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4), 1902(a)(6), and 1903 of the Social Security Act, with respect to non-payment for provider-preventable conditions.

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Section 4.19-B:

__X__Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

_____Additional Other Provider-Preventable Conditions identified below effective for discharges on or after July 1, 2014:

- Post-operative death in normal healthy patient
- Death/disability associated with use of contaminated drugs, devices or biologics
- Death/disability associated with use of device other than as intended
- Death/disability associated to medication error
- Maternal death/disability with low risk delivery
- Death/disability associated with hypoglycemia
- Death/disability associated with hyperbilirubinemia in neonates
- Death/disability due to wrong oxygen or gas

State Plan Under Title XIX of the Social Security Act

Medical Assistance Program

State: South Carolina

Section 2702 of the Patient Protection and Affordable Care Act of 2010 prohibits Federal payments to States under section 1903 of the Social Security Act for any amounts expended for prohibited medical assistance for certain provider-preventable conditions (PPC) and health care-acquired conditions (HCAC) for dates of service on/after September 7 2012. This policy applies to all individuals for which Medicaid is primary and those dually eligible for both the Medicare and Medicaid programs, and South Carolina Medicaid enrolled hospitals except for Indian Health Services. Reduced payment to providers is limited to the amounts directly identifiable as related to the PPC and the resulting treatment.

The following method will be used to determine the related reduction in payments for Other Provider-Preventable Conditions which includes Never Events as defined by the National Coverage Determination for Ambulatory Surgical Centers (ASC) and practitioners:

A. Dates of service beginning on/after September 7, 2012:

   1. The claims identified with a Present on Admission (POA) indicator of "Y" or "U" and provider-preventable conditions through the claims payment system will be reviewed.

   2. When the review of claims indicates an increase of payment to the provider for an identified provider-preventable condition, the amount for the provider-preventable condition will be excluded from the providers' payment.

B. No reduction in payment for a provider preventable condition will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.

C. Reductions in provider payment may be limited to the extent that the following apply:

   1. The identified provider-preventable conditions would otherwise result in an increase in payment.

   2. The State can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the provider provider-preventable conditions.

   3. Non-payment of provider-preventable conditions shall not prevent access to services for Medicaid beneficiaries.

D. Non-payment of provider-preventable conditions shall not prevent access to services for Medicaid beneficiaries

Reimbursement Template -Physician Services

Increased Primary Care Service Payment 42 CFR 447.405, 447.410, 447.415

Attachment 4.19-B: Physician Services 42 CFR 447.405 Amount of Minimum Payment

The state reimburses for services provided by physicians meeting the requirements of 42 CFR 447.400(a) at the Medicare Part B fee schedule rate using the Medicare physician fee schedule rate in effect in calendar years 2013 and 2014 or, if greater, the payment rates that would be applicable in those years using the calendar year 2009 Medicare physician fee schedule conversion factor. If there is no applicable rate established by Medicare, the state uses the rate specified in a fee schedule established and announced by CMS.

☒ The rates reflect all Medicare site of service and locality adjustments.

☐ The rates do not reflect site of service adjustments, but reimburse at the Medicare rate applicable to the office setting.

☐ The rates reflect all Medicare geographic/locality adjustments.

☐ The rates are statewide and reflect the mean value over all counties for each of the specified evaluation and management and vaccine billing codes.

The following formula was used to determine the mean rate over all counties for each code:_____

Method of Payment

☒ The state has adjusted its fee schedule to make payment at the higher rate for each E&M and vaccine administration code.

☐ The state reimburses a supplemental amount equal to the difference between the Medicaid rate in effect on July 1, 2009 and the minimum payment required at 42 CFR 447.405.

Supplemental payment is made: ☐ monthly ☐ quarterly ☐semi-annually ☐annually

Primary Care Services Affected by this Payment Methodology

☐ This payment applies to all Evaluation and Management (E&M) billing codes 99201 through 99499.

☒ The State did not make payment as of July 1, 2009 for the following codes and will not make payment for those codes under this SPA (specify codes).

99224 E/M SUBSEQ OBS CARE PER DAY,LEVEL 1
99225 E/M SUBSEQ OBS CARE PER DAY,LEVEL 2
99226 E/M SUBSEQ OBS CARE PER DAY, LEVEL 3
99340 MD SUPV PT HM,DOM/RST HM/MONTH/30+ MIN
99355 PROLONGED PHY SERV OFF OR OP EA ADD 30 M
99357 PROLONGED PHY SERV IP EA ADD 30 MIN
99358 PROLONGED EVAL & MANAGEMENT SERV 1 HR
99359 PROLONGED EVAL & MANGEMENT EA ADD 30 MIN
99363 ANTICOAGULANT MGMT,WARFARIN,INIT 90 DAYS
99364 ANTICOAGULANT MGMT,WARFARIN,EA SUBSEQ 90
99366 TEAM CONF PROF W/PAT/FAM,30 MIN OR MORE
99367 TEAM CONF PROF W/PAT/FAM,30 MIN W/ PHYS
99368 TEAM CONF PROF NO PAT/FAM PRESENT,30MIN
99374 PHY CARE OVERSIGHT-HOM HLTH PAT;15-29MIN
99375 PHY CARE PLAN OVERSIGHT SERV 30-60 MIN
99377 PHY CARE OVERSIGHT-HOSPICE PAT;15-29MIN
99378 PHY CARE OVERSIGHT-HOSPICE PAT;30+ MINUT
99379 PHY CARE OVERSIGHT-NURS FAC PAT;15-29MIN
99380 PHY CARE OVERSIGHT-NURS FAC PAT;30+ MINU
99411 E/M PREVENT MED SERV GRP COUNSEL @ 30MIN
99412 E/M PREVENT MED SERV GRP COUNSEL @ 60MIN
99420 E/M OTHR PREV MED SERV ADMIN & INTERPRET
99429 E/M UNLISTED PREVENTIVE MEDICINE SERVICE
99441 PHONE E/M BY PHYS,EST PATIENT,5-10 MIN
99442 PHONE E/M BY PHYS,EST PATIENT,11-20 MIN
99443 PHONE E/M BY PHYS,EST PATIENT,21-30 MIN
99444 ONLINE E/M PHY,EST PT,NO VIS W/IN 7 DAY
99450 BASIC LIFE AND/OR DISABILITY EXAM
99455 WORK RELATED OR DISABILITY EX, TREAT PHY
99456 WORK RELATED/DISABILITY EX,NOT TREAT PHY

(Primary Care Services Affected by this Payment Methodology – continued)

☒ The state will make payment under this SPA for the following codes which have been added to the fee schedule since July 1, 2009 (specify code and date added).

99224	E/M SUBSEQ OBS CARE PER DAY,LEVEL 1	1/1/2011
99225	E/M SUBSEQ OBS CARE PER DAY,LEVEL 2	1/1/2011
99226	E/M SUBSEQ OBS CARE PER DAY, LEVEL 3	1/1/2011
99406	SMOK/TOBACCO CESSATION COUNS, 3-10 MIN	2/1/2012
99407	SMOK/TOBAC CESSATION, INTENSIVE<10MIN	2/1/2012
90460	IMMUN ADMIN <=AGE 18; ANY ROUTE,1ST VACC	1/1/2011
90461	IMMUN ADMIN <=AGE 18; ANY ROUTE,EA ADD'L	1/1/2011

Physician Services – Vaccine Administration

For calendar years (CYs) 2013 and 2014, the state reimburses vaccine administration services furnished by physicians meeting the requirements of 42 CFR 447.400(a) at the lesser of the state regional maximum administration fee set by the Vaccines for Children (VFC) program or the Medicare rate in effect in CYs 2013 and 2014 or, if higher, the rate using the CY 2009 conversion factor.

☐ Medicare Physician Fee Schedule rate

☒ State regional maximum administration fee set by the Vaccines for Children program
1.

☐ Rate using the CY 2009 conversion factor

Documentation of Vaccine Administration Rates in Effect 7/1/09

The state uses one of the following methodologies to impute the payment rate in effect at 7/1/09 for code 90460, which was introduced in 2011 as a successor billing code for billing codes 90465 and 90471.

☐ The imputed rate in effect at 7/1/09 for code 90460 equals the rate in effect at 7/1/09 for billing codes 90465 and 90471 times their respective claims volume for a 12 month period which encompasses July 1, 2009. Using this methodology, the imputed rate in effect for code 90460 at 7/1/09 is:_____.

☒ A single rate was in effect on 7/1/09 for all vaccine administration services, regardless of billing code. This 2009 rate is: $13.00.

☐ Alternative methodology to calculate the vaccine administration rate in effect 7/1/09:_____
_____
_____

2.

Note: This section contains a description of the state's methodology and specifies the affected billing codes.

Effective Date of Payment

E & M Services
This reimbursement methodology applies to services delivered on and after January 1, 2013, ending on December 31, 2014 but not prior to December 31, 2014. All rates are published at www.scdhhs.gov. The state is using a fee schedule that was developed using the tools provided by Deloitte. The fee schedule will not be adjusted for changes in Medicare's rates throughout the year. We will update the fee schedule in December to reflect the changes effective January 1, 2014.

Vaccine Administration
This reimbursement methodology applies to services delivered on and after January 1, 2013, ending on December 31, 2014 but not prior to December 31, 2014. All rates are published at www.scdhhs.gov.

Supercedes Page: None

PRA Disclosure Statement
According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 20 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.