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%
Physician Services	Page 2a.2/Section 5	• Pediatric Subspecialist – 2% rate reduction (except Neonatologists) • Reduce Labor and Delivery reimbursement from $1164 to $1100 for Vaginal delivery and $1000 for C-section delivery • Family Practice, General Practice, Osteopath, Internal Medicine, Pediatrics, Geriatrics - 2% rate reduction • Anesthesiologists – 3% rate reduction • All other physicians except Obstetrics, OB/GYN, Maternal Fetal Medicine - 5% rate reduction • EPSDT Well Visit codes – 2% rate reduction
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, mental health 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 hospitals that are eligible to receive retrospective cost reimbursement and fall under the 10th 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 75th percentile methodology will be reimbursed the lower of allowable actual Medicaid reimbursable outpatient hospital costs or Medicaid outpatient hospital payments at the 75th percentile for services provided on or after July 1, 2014.

- 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.

  Therefore, effective for outpatient hospital services provided on or after October 1, 2014, the SC hospitals meeting this SC defined rural hospital criteria will receive retrospective cost settlements that represent one hundred percent (100%) of allowable SC Medicaid outpatient hospital costs which includes, base, capital, and Direct Medical Education (DME) costs subject to the exceptions provided in the July 1, 2014 outpatient hospital normalization action.

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. 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.

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- 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

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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 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.

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.

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 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 October 1, 2013

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.

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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 outpatient (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.

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 services. This ratio will be calculated using cost from worksheet B part I (column 24, applicable lines from 50-117), charges from worksheet C (column 8), and Medicaid settlement data from worksheet D part V (columns 2, 3, and 4). 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 settlement 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 for services provided on or after July 1, 2014.

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 Medicare Inpatient Hospital Market Basket Index rate (prior to productivity adjustment) for FY 13, FY 14, and FY 15 in order to trend the base year cost (HFY 2013) to the Medicaid rate period October 1, 2014 through September 30, 2015.

(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.

(5) Next, the Department divided the Medicaid outpatient hospital revenue for each hospital by the weighted average hospital specific outpatient multipliers based upon the October 1, 2011, November 1, 2012, and October 1, 2013 multipliers to determine the Statewide Outpatient Hospital Fee Schedule payments received by each hospital during the base year period.

(6) Next, to account for the October 1, 2014 hospital specific outpatient multiplier update, the Department multiplied the October 1, 2014 hospital specific outpatient multipliers against the Statewide Outpatient Hospital Fee Schedule payments received by each hospital during the base year (see step (5))to determine projected Medicaid outpatient hospital revenue for FFY 2015. For hospitals that continue to receive retrospective cost settlements at 100% of allowable costs on and after October 1, 2014, the estimated revenue for the FFY 2015 payment period equals the trended inflated cost as described in step (3) subject to the exceptions granted in the July 1, 2014 normalization action.

(7) 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 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:

Effective January 1, 2001, in accordance with BIPA 2000, an alternative payment methodology will be used for reimbursement of Federally Qualified Health Centers (FQHCs). The alternative payment methodology is described below. It has been determined by a comparison of rates using the prospective payment methodology (PPS) and the current alternative payment methodology that the alternative methodology as described will provide reimbursement to FQHCs which is at least equal to the amount that would be received using the PPS methodology. The FY 01 baseline 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 alternative payment methodology is a cost based retrospective reimbursement system. The SCDHHS uses a modified Medicare RHC actual cost report as the cost report format for FQHCs. The reports, as submitted, shall be reviewed for accuracy, reasonableness and the allowability of costs as defined by Medicare reasonable cost principles. Reimbursement will be made at 100% of Medicare reasonable costs with the following constraints: (1) The minimum productivity level for physicians shall be 4,200 patient visits per year; for mid-level practitioners, 2,100 patient visits per year; and for OB/GYN physicians, 3,360 patient visits per year; (2) Overhead costs shall be limited to not more than thirty percent (30%); and, (3) Out-of-state FQHCs shall be paid the statewide encounter rate as determined from the most recently completed state fiscal year. To ensure that reimbursement will be made at 100% of Medicare reasonable costs, subject to the above mentioned constraints, adjustment to cost shall be made on a retrospective basis based upon review of the FQHCs' fiscal year end cost report. Furthermore, the reported cost information shall be used for establishing or modifying the rates of payment for future services rendered by the FQHC.

For those facilities that are not PHS grantees but are designated as "look alikes", the same cost principles and constraints shall apply as mentioned above for FQHCs.

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

Circumstances requiring special consideration/disposition are outlined below:

1. For FQHCs 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 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. Reimbursement will be reconciled to actual cost on an annual basis based on the FQHC's fiscal year. 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.

3. For those FQHCs 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 FQHC does not receive less reimbursement than would be received under the cost based or PPS reimbursement methodologies. An annual reconciliation of quarterly supplemental payments will be included in the FQHC's fiscal year cost settlement and rate determination.

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.

Coinsurance and Deductibles will be paid by the Medicaid Program (Title XIX) program where the individual has joint eligibility for Medicare and Medicaid.

both programs; however, The Medicare (Title XVII) program is primarily responsible for reimbursement in these cases. Non-Medicare benefits will follow the South Carolina Medicaid State Plan as described in 42 CFR 337.371 (c) (2).

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. 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. .

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

Reimbursement for Early and Periodic Screening, Diagnosis and Treatment Screening Services are reimbursed 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. 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.

Comprehensive Health and Developmental History including
Assessment of both Physical and Mental Health Development
Assessment of Nutritional Status
Comprehensive Unclothed Physical Examination
Ear, Nose, Mouth and Throat Inspection
Developmental Assessment
Assessment of Immunization Status and Administration
Vision Screening
Hearing Screening
Blood Pressure
Anemia Screening
Health Education

Optional services as deemed medically necessary by the provider:

Lead Screening
Sickle Cell Test
Tuberculin Skin Test
Parasite Test
Urinalysis

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. 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 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. The reimbursement rate for these services will

be 80% of statewide usual and customary fees. 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 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.

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.

the above methods work, the agency will look at a similar type service and determine a one-time reimbursement rate that is agreeable to both the agency and the provider based upon a review of charges (i.e. paying a percentage of billed charges), commercial market rates, or cost report data.

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 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 July 1, 2007 and is effective for services provided on or after that date. All rates are published in Medicaid Bulletins. The SCDHHS will limit the weekly reimbursement of Home Based Private Duty Nursing services provided by either a RN or LPN to the amount of weekly institutional care reimbursement based upon the intensive technical services reimbursement rate as established via Attachment 4.19-D, Page 30, of the South Carolina State Plan.

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. The SCDHHS will limit the weekly reimbursement of Home Based Private Duty Nursing services provided by either a RN or LPN to High Risk/High Tech children to the amount of weekly institutional care reimbursement based upon the intensive technical services reimbursement rate as established via Attachment 4.19-D, Page 30, of the South Carolina State Plan.

Personal Care Services:

The Personal Care service reimbursement rate was initially established based upon projected service costs of providers. The payment rate is calculated for Personal Care services on an hourly basis. 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 OMB Circular A-87. 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. 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 in Medicaid Bulletins.

Autism Services

Effective for services provided on and after July 1, 2017, the Medicaid agency will reimburse both private and governmental providers of autism services based upon a state developed fee schedule. The services to be provided under this section are as follows and can be accessed via the following agency website address: https://msp.scdhhs.gov/autism/site-page/fee-schedule

Procedure Code	Service Description	Qualifications	Unit
0359T	Behavior Identification Assessment (ABA)	**BCBA/BCaBA**	30 minutes
90791	Behavior Assessment (non-ABA)	**Ph.D./Psy.D., LISW, LMFT, LPC, LPES**	Encounter
0368T & 0369T	Adaptive Behavior Treatment With Protocol Modification	**BCBA/BCaBA**	30 minutes
0360T & 0361T	Observational Behavioral Follow-up Assessment	**BCBA/BCaBA/RBT II**	30 minutes
0362T, 0363T	Exposure Behavioral Follow-up Assessment	**BCBA/BCaBA** **RBT I & RBT II**	30 minutes
0364T, 0365T	Adaptive Behavior Treatment By Protocol	**BCBA/BCaBA** **RBT I & RBT II**	30 minutes
0370T	Family Adaptive Behavior Treatment Guidance	**BCBA/BCaBA**	30 minutes
H2019	Therapeutic Behavioral Services (Non-ABA)	**Ph.D./Psy.D., LISW, LMFT, LPC, LPES**	15 minutes

In order to determine the fee schedule rates for the procedure code rates listed above, the agency first employed the use of its current Pervasive Developmental Disorder Waiver (PDD) rates and cross-walked the rates and PDD procedure codes to the new autism service procedure codes. 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 used the midpoint of the comparable South Carolina state government positions and determined the average hourly rate for BCBA/BCaBA staff. After applying the applicable fringe rate and adding estimated operational expenses (travel, training and 10% indirect rate), the sum was divided by an estimated number of billable hours to determine an hourly billing rate. To convert the hourly rate to a thirty minute unit rate, the Medicaid agency simply reduced the hourly rate by fifty percent. This methodology would apply to procedure codes 0368T, 0369T, and 0370T. The rate for procedure code 0359T provided by BCBA/BCaBA staff is derived from comparable state developed fee schedule rates currently in existence.

To determine an hourly rate for the services provided by a Registered Behavior Technician I (RBT I) or a Registered Behavior Technician II (RBT II), the Medicaid Agency used the midpoint of the comparable South Carolina state government position and determined the average hourly rate for a RBT I as well as a RBT II. After applying the applicable fringe rate and adding estimated operational expenses (travel, training and 10% indirect rate) for a RBT I and a RBT II, the sum of each position was divided by an estimated number of billable hours to determine an hourly billing rate. To convert the hourly rate to a thirty minute unit rate, the Medicaid agency simply reduced the hourly rate by fifty percent. Because procedure codes 0360T, 0361T, 0362T thru 0365T account for the majority of services provided under this section, the Medicaid Agency applied a 27.25% trend factor to these procedure code rates to ensure adequate compensation for the services provided.

Finally, to determine the rates for procedure codes 90791 and H2019, the rates were established using state developed fee schedule rates currently in effect as follows:

- Procedure code H2019 was priced by using the rate paid to private providers of mental health services under procedure code 90832 provided by a masters level individual and reduced by 50% to account for the change in unit measurement (i.e. from 30 minutes to 15 minutes).

- Procedure code 90791 was priced by using the rate paid to private providers of mental health services and provided by a master’s level individual.

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. The State shall utilize Medicare reasonable cost principles as well as OMB Circular A-87 and other OMB circulars as may be appropriate during its review of actual allowable costs. 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) and any annual/periodic adjustments to the fee schedule are published in Medicaid Bulletins. The agency's fee schedule rates were set as of October 1, 2009 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. See page 0 of Attachment 4.19-B. All physician services will be reimbursed based on a Fee Schedule that in the aggregate will not exceed 100 percent of Medicare.

Payment to pediatric subspecialists (excluding Neonatologists) are paid 116.4 percent of the 2009 SC Medicare Fee Schedule. This rate was last updated on July 11, 2011. Payment to Neonatologists are paid 115 percent of the 2009 SC Medicare Fee Schedule. This rate was last updated on April 8, 2011. See page 0 of Attachment 4.19-B.

Family and general practice physicians, osteopaths, internal medicine physicians, pediatricians, and geriatricians are paid 81 percent of the 2009 Medicare Fee Schedule. This rate was last updated on July 11, 2011. See page 0 of Attachment 4.19-B.

Anesthesiologists are paid 81 percent of the 2009 SC Medicare Fee Schedule. This rate was last updated on July 11, 2011. See page 0 of Attachment 4.19-B.

All other physicians except for obstetricians, OB/GYN and maternal fetal medicine practitioners are paid 78 percent of the 2009 SC Medicare Fee Schedule. This rate was last updated on July 11, 2011. See Page 0 of Attachment 4.19-B.

EPSDT well code visits are paid 95 percent of the 2009 SC Medicaid Fee Schedule. This rate was last updated on July 11, 2011. See page 0 of Attachment 4.19-B.

Payment for vaginal deliveries is $1,100. C-section deliveries are paid $1000. This rate was last updated on July 11, 2011. See page 0 of Attachment 4.19-B.

For those procedures that are non-covered by Medicare, reimbursement is based on data collected within the Medicaid Management Information System or by a review conducted by medical personnel to establish the relative value. 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 11, 2011 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.

Enhanced Primary Care Payments

Effective for dates of service on or after January 1, 2015 Primary Care Physicians enrolled as Family Practice, General Practice, Gynecology, Internal Medicine, Obstetrics, Obstetrics & Gynecology, Pediatrics, Psychiatry, and Child Psychiatry will receive an enhanced Medicaid rate for certain Evaluation, Management and vaccine Current Procedural Terminology codes. SCDHHS will continue to utilize the fee schedule approved by CMS effective January 1, 2014 for the Federal enhanced payment program. For vaccines administration codes the state will reimburse based on the state regional maximum administration fee set by the Vaccines for Children program in effect January 1, 2014. All rates are published at www.scdhhs.gov . Below is the list of codes that qualify for enhanced payments.

Primary Care Procedure Codes											
99201	99217	99231	99243	99283	99308	99328	99347	99384	99397	99461	99472
99202	99218	99232	99244	99284	99309	99334	99348	99385	99401	99462	99475
99203	99219	99233	99245	99285	99310	99335	99349	99386	99402	99463	99476
99204	99220	99234	99251	99288	99315	99336	99350	99387	99403	99464	99477
99205	99221	99235	99252	99291	99316	99337	99354	99391	99404	99465	99478
99211	99222	99236	99253	99292	99318	99341	99356	99392	99406	99466	99479
99212	99223	99238	99254	99304	99324	99342	99360	99393	99407	99467	99480
99213	99224	99239	99255	99305	99325	99343	99381	99394	99408	99468	99499
99214	99225	99241	99281	99306	99326	99344	99382	99395	99409	99469	
99215	99226	99242	99282	99307	99327	99345	99383	99396	99460	99471	
Vaccines Administration Codes											
90460	90461	90471	90472	90473	90474						

Effective July 1, 2005, pediatric sub-specialist providers will receive an enhanced Medicaid rate for Evaluation & Management (E&M), medical & surgical procedure codes. These enhanced rates will not exceed 116 percent of the 2009 Medicare fee schedule for all covered E&M Current Procedural Terminology (CPT) codes 99201 – 99499. All other covered CPT codes will not exceed 97 percent of the 2009 Medicare fee schedule. The Pediatric sub-specialty fee schedule is located at http://www.scdhhs.gov/ServiceProviders/FeeSchedules.asp. 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 April 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:

- The Medicaid Agency chose the base period of October 1, 2013 through September 30, 2014 in order to ensure that all claims incurred during the base period were captured.

- 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.

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- 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.

- 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, Palmetto Health Richland, Self Memorial Hospital, Spartanburg Regional Medical Center, and the University of South Carolina College of Medicine.

6.a Podiatrists' Services:

Reimbursement is calculated in the same manner as for Physicians' services (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.b Optometrists' Services (Vision Care Services):

Reimbursement is calculated in the same manner as for Physicians' services - (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 in the same manner as for Physicians' services (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.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 Family and General Practice Physician fee schedule, which is set at 81 percent 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.

Physician Assistant: Effective for services provided on or after October 1, 2015, reimbursement is calculated at 80 percent of the Family and General Practice Physician fee schedule, which is set at 81 percent 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.

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 Medicare costs, charges, or the Medicare 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:

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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. This rate was last updated on July 11, 2011. 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	30 minutes	6
Family Therapy, client present (Fm Tx)	90847	30 minutes	6
Group Therapy (Gp Tx)	90853	30 minutes	8
Individual Therapy (Ind Tx)	90804	30 minutes	6
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)	90801	15 minutes	6
Psychiatric Medical Assessment-Advanced Practice Registered Nurse (PMA-APRN)	90801 TD	15 minutes	6
Psychiatric Medical Assessment – Telepsychiatry (PMA-T)	90801 GT	15 minutes	6

Interim Rates

Medicaid interim rates for mental health services in community mental health centers are established utilizing Medicare reasonable cost principles, as well as OMB Circular A-87. 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 in Provider Reimbursement Manual HIM-15.

Annual Cost Identification and 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 the Provider Reimbursement Manual HIM-15:

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 injectables), 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:

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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, and

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 HIM-15.

Indirect Costs:

Allowable indirect costs will be determined and allocated in accordance with cost allocation methodologies as allowed in the Provider Reimbursement Manual HIM-15.

The results of total allowable costs divided by total units of service per service definition become the average allowable unit rates for reconciliation and cost settlement. 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 amount is compared to 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, SCDHHS will send a letter to the provider requesting repayment within 30 days. Should the comparison referred to above identify an underpayment to the provider, SCDHHS will send inform the provider and initiate a gross adjustment to the provider through the MMIS.

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. OPACs are reimbursed through two all inclusive rates. The services are as follows:

Multidisciplinary Clinic Visit with Physician (T1025) and
Lab Only Clinic Visit (T1015)

Outpatient Pediatric Aids services were developed during the period July 1, 1993 to July 1, 1994. Budgets were used from the three governmental providers of this service to establish the all inclusive rates. Costs included in these budgets included: 1) personnel costs – the salary and fringe benefit costs associated with direct providers of service dedicated to the OPAC service, 2) supplies – material and supply costs that are required for direct services to patients, 3) indirect costs – as determined by the application of the provider's federally approved indirect cost rate or federally approved indirect cost plan. Rate updates are allowed upon presentation of substantiated cost increases. The latest rate update was in July 2007.

Reconciliation of Annual Cost Reports to Interim Payments (OPAC Providers):
All OPAC providers 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 OMB-A87 cost definitions and principles.

Direct Costs:

1) Personnel costs – Expenditures from the accounting records of the provider for the incurred salaries, payroll taxes, and fringe benefits for the employees providing direct medical services to beneficiaries in the OPAC 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 injectables), 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 practitioner,

3) Training and travel expenses that directly relate to maintaining certification, qualifications, or licensure for practitioners 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.

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 HIM-15, using either the step down cost allocation method (HIM-15, Chapter 2300) or the functional allocation method (HIM-15, Chapter 2100, Section 2150.3).

The results of total allowable costs divided by total units of service per service definition become the allowable unit rate for each service. . For state owned governmental OPAC providers that use certified public expenditures as the source of state match, the allowable unit rate for each service is multiplied by the applicable Medicaid units of service (as determined by the SCDHHS MMIS) to determine the Medicaid reimbursable cost of

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each service. These results are summed to become the maximum allowable Medicaid costs for the state owned governmental provider. This amount is then compared to Medicaid interim payments (including TPL) and any prior adjustments and/or recoupments for these services. In the event that Medicaid interim payments exceed the maximum allowable Medicaid costs, the state owned governmental provider will be required to refund the overpayment to the Medicaid agency. However if an underpayment occurs, no additional payments will be made to the state owned governmental provider. This payment methodology will sunset September 30, 2014.

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.

The infusion center rates were modeled after the Medicare infusion therapy payment methodology prior to HIPAA implementation in 2003. The most recent updates to this fee schedule occurred in October 2009. Infusion center rate updates are published in Medicaid bulletins and are the same for governmental and private providers of this service.

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. This percentile was determined by an independent company's analysis of all dental claims filed in the state within the calendar year. The current reimbursement will not exceed the 75th percentile of usual and customary reimbursement. Please click http://www.scdhhs.gov/resource/fee-schedules to access the dental services fee schedule. The State developed fee schedule was last updated July 11, 2011 and are the same for governmental and private providers of this service.

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

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

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. 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.

13.c Preventive Services

Preventive services for Primary Care Enhancement as defined in 3.1-A, pages 6 and 6a, paragraph 13c. 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)

Medicaid reimbursement rates for preventive services for Primary Care Enhancement will be established utilizing Medicare reasonable cost principles, as well as OMB Circular A-87 and other OMB circulars as may be appropriate. For each level of service that is paid for on a per unit basis, budgeted costs will be used in determining the initial rates for each. Budgeted costs may include personnel costs (including fringe benefits), operating costs (such as building and equipment maintenance, repairs, depreciation, amortization, and insurance expenses; employee travel and training expenses; utilities; plus material and supply expenses); as well as indirect costs and general and administrative overhead costs. The initial rates will be determined by dividing the budgeted costs by the projected units of service. However, the initial rate for each level of service can not exceed the maximum rate cap established for each level of service. A unit of service for preventive services for Primary Care Enhancement is defined as fifteen (15) minutes of service delivery.

All providers (i.e., private and public) of preventive services for Primary Care Enhancement will be required to submit annual cost reports for each level of service for which they are reimbursed. The cost reports shall include the actual costs of providing each service level as well as service delivery data utilizing the established defined unit of service. These reports will be used to analyze the appropriateness and reasonableness of the reimbursement rates as well as to verify that the Medicaid reimbursement does not exceed the actual allowable costs of providing services. Cost settlements will be performed each year as a result of the submission of the annual cost reports. However, Medicaid reimbursement will be limited to the lower of actual allowable Medicaid costs or the maximum rate cap established for each level of service. The maximum rate cap for each level of service will be established each year using the financial and service delivery data of the largest volume provider of the service. Additionally, future reimbursement rates for providers will be the lesser of the providers actual unit cost or the maximum rate that has been established.

This reimbursement methodology will expire September 30, 2012.

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

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- 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 http://www.scdhhs.gov/whatsnew.asp. 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.

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 HIM-15, using either the step down cost allocation method (HIM-15, Chapter 2300) or the functional allocation method (HIM-15, Chapter 2100, Section 2150.3). 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 OMB- A87 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 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)

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

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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 .

Medicaid reimbursement rates for rehabilitative services for Primary Care Enhancement will be established utilizing Medicare reasonable cost principles, as well as OMB Circular A-87 and other OMB circulars as may be appropriate. The rates will represent composite rates, in that professional and paraprofessional costs will be combined in order to establish one rate for each service. For each level of service that is paid for on a per unit basis, budgeted costs will be used in determining the initial rates for each. Budgeted costs may include personnel costs (including fringe benefits), operating costs (such as building and equipment maintenance, repairs, depreciation, amortization, and insurance expenses; employee travel and training expenses; utilities; plus material and supply expenses); as well as indirect costs and general and administrative overhead costs. The initial rates will be determined by dividing the budgeted costs by the projected units of service. However, the initial rate for each level of service can not exceed the maximum rate cap established for each level of service. A unit of service for rehabilitative services for Primary Care Enhancement is defined as fifteen (15) minutes of service delivery.

All providers (i.e., private and public) of rehabilitative services for Primary Care Enhancement will be required to submit annual cost reports for each level of service for which they are reimbursed. The cost reports shall include the actual costs of providing each service level as well as service delivery data utilizing the established defined unit of service. These reports will be used to analyze the appropriateness and reasonableness of the reimbursement rates as well as to verify that the Medicaid reimbursement does not exceed the actual allowable costs of providing services. Cost settlements will be performed each year as a result of the submission of the annual cost reports. However, Medicaid reimbursement will be limited to the lower of actual allowable Medicaid costs or the maximum rate cap established for each level of service. The maximum rate cap for each level of service will be established each year using the financial and service delivery data of the largest volume provider of the service. Additionally, future reimbursement rates for providers will be the lesser of the providers' actual unit cost or the maximum rate that has been established.

Personal Care Service - The rate paid to providers of Personal Care services equals the rate paid to providers of Personal Care services. This methodology is described under page 2, paragraph 4.b of Attachment 4.19-B. A unit of service equates to one hour. This rate does not cover room and board services provided to Medicaid recipients. State developed fee schedule rates are the same for both public and private providers and the fee schedule and any annual/periodic adjustments to the fee schedule are published in Medicaid Bulletins. The agency's fee schedule rate was set as of October 1, 2007 and is effective for services provided on or after that date.

17. Nurse Midwife Services:

Self-employed - Reimbursement is calculated at 80% of the current physician allowable amount for the delivery and 100% of the current physician allowable amount.

Employed - Reimbursement is calculated at 100% of the current physician allowable amount

18. Hospice Services:

With the exception of payment for physicians services reimbursement for hospice services is made at one of four predetermined rates for each day in which an individual is under the care of the hospice. The rate is no lower than the rates used under Part A of Title XVIII Medicare, adjusted to disregard cost offsets attributable to Medicare coinsurance, using the same methodology used under Part A. The four rates are prospective rates. There are no retroactive adjustments other than the limitation on payments for inpatient care. The rate paid for any particular day varies depending on the level of care furnished to the individual.

In addition to the four reimbursement rates of the services described below, Hospice providers are also required to reimburse nursing facilities and ICF/MR facilities for the Hospice Long Term Care Room and Board per diem. This amount is paid to the hospice on behalf of an individual residing in a Nursing Facility or Intermediate Care Facility for the mentally retarded. Effective October 1, 2008,the Hospice Agency is responsible for reimbursing nursing facilities and intermediate care facilities for the mentally retarded 98% of the daily room and board rate.

The four reimbursement rates are applicable to the type and intensity of the services (level of care) furnished to the individual for that day. The four levels of care into which each day of care is classified are:

- Routine Home Care
- Continuous Home Care
- Inpatient Respite Care
- General Inpatient Care

For continuous home care, the amount of payment is determined based on the number of hours of care furnished to the patient on that day.

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 intermediate care facilities for the mentally retarded. Upon receipt of the Medicaid reimbursement, the Hospice providers will forward the reimbursement to the facility in which the Medicaid beneficiary resides.

Limitations on Inpatient Care

Payments to a hospice for inpatient care must be limited according to the number of days of inpatient care furnished to Medicaid patients. The requirements found in 42 CFR 418.302(f)(l)-(5) will be imposed when implementing the limitations on inpatient care.

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.a Case Management Services:

Case management services for patients with mental retardation and related disabilities will be reimbursed through a fee for service methodology which will actually be a monthly management fee for each patient case managed. The monthly rate reflects all direct costs associated with case management service delivery, per individual case manager, per average monthly caseload. The rate will be prospectively determined by using an average ideal monthly caseload, and based on the average cost of the social worker including support costs. Payment to state agency providers will not exceed the cost of rendering the service. The requirements of 42 CFR 447.321 or 42 CFR 447.325 will not be exceeded.

19.b Case management services for severely emotionally disturbed children will be reimbursed through a fee for service methodology based on the delivery of units of service. A unit of service will be fifteen (15) minutes. The payment rate for a unit of service will be prospectively determined based on the salary of case managers as well as other applicable operating costs. An adjustment based on the actual cost of the delivery of services will be made at the end of each fiscal year. Payment to state agency providers will not exceed the cost of rendering the service. The requirements of 42 CFR 447.321 or 42 CFR 447.325 will not be exceeded.

19.c Case management services for chronically mentally ill adults will be reimbursed through a fee for service methodology based ont he delivery of units of service. A unit of Service will be fifteen (15) minutes. The payment rate for a unit of service will be prospectively determined based on the salary of case managers as well as other applicable operating costs. An adjustment based on the actual cost of the delivery of services will be made at the end of each fiscal year. Payments to state agency providers will not exceed the cost of rendering the service.

19.d Case management services for seriously emotionally disturbed children will be reimbursed through a fee for service methodology based on the delivery of units of service. A unit of service will be fifteen (15) minutes. the payment rate for a unit of service will be prospectively determined based on the salary of case managers as well as other applicable operating costs. An adjustment based on the actual allowable cost of the delivery of services will be made at the end of each fiscal year. Payments to state agency and other non-profit providers will not exceed the cost of rendering the service.

19.e Case Management Services

Case Management services for "at risk" Medicaid pregnant women and their infants (up to one year past delivery), will be reimbursed through a fee for service methodology based on the delivery of units of service. The payment rate for a unit of service will be prospectively determined based on the salary of case managers as well as other applicable operating costs. An adjustment based on the actual cost of the delivery of service will be made at the end of each fiscal year. Payment to state agency providers will not exceed the cost of rendering the service.

Senior Case Managers will perform initial assessments, open cases supervise Associate Case Managers and close cases.

Case management documentation will be kept in a progress record. Documentation for follow-up and monitoring activities will include:

- date of client contact/attempt or provider contact;
- type of client contact;
- progress since last action;
- service plan actions taken during contact; and
- next scheduled contact.

19.f Case Management Services (Substance Abuse)

Case management services for Medicaid recipients who are alcohol and drug abusers will be reimbursed through a unit fee for service methodology. a unit equals fifteen (15) minutes of service contact. The unit rate for case management services will not exceed the requirements of 42 CFR 447.321 or 42 CFR 447.325. For public sector providers, the unit rate will be based on the total cost to provide the service. Only Medicaid allowable costs attributable to the provision of case management services will be used to determine the unit rate. Actual cost data will be verified through provider cost documents for each fiscal year. A year end cost settlement will assure that only actual reasonable costs are reimbursed.

For private providers, the fee for service rate will be negotiated and established by the Department of Health and Human Services (DHHS). DHHS will pay either the negotiated rate or the private provider charges, whichever is less.

19.g Case Management Services (Sickle Cell Disease)

Case Management services for Medicaid recipients with Sickle Cell Disease, will be reimbursed by a fee for services methodology based on the delivery of units of service. A unit of service will be fifteen (15) to thirty (30) minutes based on the salary of case managers as well as other applicable operating costs. An established rate per site will be based on projected cost. An annual review will determine actual State Agency and other non-profit providers costs and any adjustments to the rate. Payment to state agency providers will not exceed the cost of rendering the service.

For private providers, the fee for service rate will be negotiated and established by the Department of Health and Human Services (DHHS) based on actual cost. The DHHS will pay either the established rate or the private provider charges, whichever is less.

19.h Case Management Services (Physically Handicapped Children)

Case Management services for Physically Handicapped Children will be reimbursed through a fee for service methodology based on the delivery of units of service. A unit of service will be fifteen minutes. The payment rate for a unit of service will be prospectively determined based on the salary of case managers as well as other applicable operating costs. An adjustment based on the actual cost of the delivery of services will be made at the end of each fiscal year. Payment to state agency providers will not exceed the cost of rendering the service. The requirements of 42 CFR 447.321 or 42 CFR.325 will not be exceeded.

For private providers, the fee for service rate will be negotiated and established by the (DHHS) based on actual cost. The DHHS will pay either the established rate or the private providers charges, whichever is less.

19.i Case management services for children in foster care ages 0-21, provided by public providers, will be reimbursed through a fee for service methodology which will actually be a monthly management fee for each client case managed. The monthly rate reflects all direct costs associated with allowable case management service delivery. The rate will be prospectively determined by using an average monthly caseload and the average cost of the case manager including support costs. Payment to public providers will not exceed the cost of rendering the service. The requirements of 42 CFR 447.321 or 42 CFR 447.325 will not be exceeded.

Case management services provided by private providers will be reimbursed on a fee for service methodology based on the delivery of units of service. The unit of service will be once per month. Payment to private providers will not exceed the established statewide average cost for the service.

19.j Case management services for Medicaid recipients with Head and Spinal Cord Injury and related disabilities will be reimbursed through a fee-for-service methodology which will actually be a monthly management fee for each client case managed. The monthly rate reflects all direct costs associated with allowable case management service delivery. The rate will be prospectively determined by using an average monthly caseload and the average cost of the case manager including support costs. Payment to public providers will not exceed the cost of rendering the service. The requirements of 42 CFR 447.200-205 and 447.304 will not be exceeded.

Case management services provided by private providers will be reimbursed on a fee-for-service methodology based on the delivery of units of service. The unit of service will be a month. Payment will not exceed the established statewide average cost for the service.

19.k Case management services for Medicaid recipients who are sensory impaired will be reimbursed by a fee-for-service methodology. A unit of service will be fifteen (15) minutes. Payment rate for a unit of service will be determined by a costing methodology. A rate will be established based on projected cost that includes average case manager's salaries and other appropriate support and operating costs. The actual costs will be reviewed annually and any adjustments to the rate will be made. Payments to state agency providers will not exceed the cost of rendering the service. The requirements of 42 CFR 447.321 will not be exceeded.

19.l Case management services for juvenile justice children ages 0-21 will be reimbursed through a fee-for-service methodology which will actually be a monthly case management fee for each client case managed. Medicaid will be billed only when a case management service has been rendered to an eligible individual during any given month. The monthly rate reflects all costs associated with allowable case management service delivery. The rate will be prospectively determined by using an average anticipated monthly caseload and the average cost of the case manager including support costs. Payment to public providers will not exceed the actual allowable cost of rendering the service. Services that are not directly related to Targeted Case Management will not be included in the establishment of the Medicaid reimbursement rate. Cost settlements will be done each fiscal year to assure that payment for case management services does not exceed actual allowable cost. The requirements of 42 CFR 447.200-205 or 42 CFR 447.300, 302 and 304 will not be exceeded.

Case management services provided by private providers will be reimbursed on a fee-for-service methodology based on the delivery of units of service. The unit of service will be a month. Payment will not exceed the established statewide average cost for the service.

19.m Case management services for Adult Protective Services clients, provided by public providers, will be reimbursed through a fee for service methodology which will actually be a monthly management fee for each client case managed. The monthly rate reflects all direct costs

associated with allowable case management service delivery. The rate will be prospectively determined by using an average monthly caseload and the average cost of the case manager including support costs. Payment to public providers will not exceed the actual allowable cost of rendering the service. The requirements of 42 CFR 447.321 or 42 CFR 447.325 will not be exceeded.

Case management services provided by private providers will be reimbursed on a fee-for-service methodology based on the delivery of units of service. The unit of service will be a month. Payment to private providers will not exceed the established statewide average cost for the service.

As of June 30. 2006, services will no longer be covered and reimbursed.

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SUPERSEDES: MA 04-001

19.n Targeted case management (TCM) services are provided to Medicaid eligible recipients determined to meet the criteria of functionally impaired adults. 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 this population 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 - We obtained from the South Carolina Department of Social Services (SCDSS), Division of Adult Services, the personnel classifications (from the South Carolina Office of Human Resources (SCOHR) Classifications Manual) of the case managers and their supervisors employed in their Division. Note: This state agency will be a primary provider of these Targeted Case Management services. The SCDSS, Division of Adult Services, also provided the average annual salary for their case managers (Human Services Specialist II) as well as case manager supervisors (Human Service Coordinator I).

   These annual averages were used as the base salary costs in the determination of an hourly rate for case management services.

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

   1) the annual average salary for a case manager supervisor as obtained from SCDSS is multiplied by the number of case manager supervisors in the SCDSS, Division of Adult Services (i.e. statewide),

   2) this product is multiplied by the average percentage of time case manager supervisors spend on clinical supervision activities,

   3) the total average salary for all case manager supervisors <u>for clinical activities</u> as calculated above in number 2 of 1a Clinical Supervision is divided by the number of case managers workers in the SCDSS, Division of Adult Services (i.e. statewide). The result obtained represents the annual average clinical supervision salary per 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.

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1c. Allowable TCM salary costs 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. Travel/transportation costs – The travel expenses associated with visits to the client's home for assessment(s) and monitoring.

2b. Training - Training expenses that directly relate to maintaining certification, qualifications, or licensure for case managers but **not** to obtain their initial certification.

2c. 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.

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. This is in accordance with OMB A-87, Attachment A, section G.

4. Cost as identified in steps 1 though 3 above are totaled to determination the average annual costs (per case manager) incurred in the provision of targeted case management services to functionally impaired adults.

5. The maximum number of billing hours that could be anticipated for each case manager was determined. Assuming a billing productivity factor of 60%, the maximum number of billing hours for each case manager was calculated to be 1,170 hours. The calculation is as follows 37.5 hours per week X 52 weeks X 60% =1,170 hours.

6. Next, the average annual cost determined in step 4 above is divided by the maximum number of annual billable hours as determined in (5) above to arrive at an hourly rate for each case manager. The unit measurement for TCM is fifteen (15) minutes. Therefore, the hourly rate is divided by four in order to arrive at the unit billing rate.

The Medicaid agency will reimburse private providers of Targeted Case Management services to functionally impaired adults using the Medicaid rate methodology described above. Also, the interim rate paid to state owned governmental providers of Targeted Case Management functionally impaired adults will be based upon the Medicaid rate methodology described above. Reimbursement rates for Targeted Case Management services to functionally impaired adults effective July 15, 2010 (and subsequent updates) will be published in Medicaid bulletins distributed to affected providers. 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.

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

Each State Owned governmental provider rendering Targeted Case Management services to functionally impaired adult 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:

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 case management services to functionally impaired adults. For employees who are not assigned to work 100% of their time in services to functionally impaired adults, 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 as described in "Supplement 1 to Attachment 3.1-A", pages 1m.2 and 1m.3 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

c) used by the "hands-on" medical provider or case manager.

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

4) Travel/transportation costs the travel expenses associated with visits to the client's home for assessment(s) and monitoring.

   The State owned 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.

5) 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 clinical 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 clinical 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 HIM-15, Chapter 2300, Section 2313.2 (E) will be used to determine clinical supervision costs.

Indirect Costs:

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

Total Allowable Costs of Targeted Case Management services:

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

Service Statistics:

All 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. The unit measure for this service for all providers, private and governmental, is fifteen (15) minutes.

Reconciliation of Annual Cost Reports to Interim Payments:

The State owned 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 OMB-A87 cost definitions and principles. The result of total allowable costs divided by total units of service (as defined on page 6e.3 in Service Statistics) 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.

Settlement Procedures:

Should the comparison referred to above (in the Reconciliation of Annual Cost Reports to Interim Payments) 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.

This plan expires June 30, 2012.

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 provides 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. The Agency's rates were last updated on October 1, 2007 and are effective for services on or after that date. All rates are published in Medicaid bulletins. 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).

Special Needs Transportation:

Special Needs Transportation (SNT), as defined on page 9e of Attachment 3.1-A, Limitation Supplement is reimbursed based on a statewide route rate per child. The public provider of this service, the State Department of Education (SDE), is reimbursed an interim rate, which is cost settled at year-end. Please note that the initial interim rate for SNT services was based on the cost finding process as described below, utilizing estimated costs and service statistics. Interim rates are now adjusted based on current cost trends as supported by the most recently reviewed cost report for the SNT provider (i.e. the most recently reviewed cost report establishes the next period's interim rate.)

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.

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The rate development and cost finding methods for Special Needs Transportation are summarized below:

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 of OMB A-87. 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 of OMB A-87. 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.

Year End Reconciliation and Cost Settlement:

An annual cost report for the SNT program is required each year and covers the period July 1 through June 30. The report is prepared by the State Department of Education and is a compilation of incurred costs from their accounting records as well as cost obtained from the school districts from their annual audited financial statements.
SCDHHS staff reviews the Transportation Route Based Reimbursement Calculation and supporting work papers filed by SDE for accuracy, consistency with prior submissions and correct application of OMB A-87 provisions. Any questionable items are forwarded to the appropriate staff at SDE for resolution prior to final determination of annual SNT rate and subsequent cost settlement.
To complete this review, staff requests payment data from the MMIS reporting system (MEDSTAT) which reflects paid units of service (i.e. routes) and the Medicaid payments associated with these units of service. To complete the annual cost settlement for SNT services, the desk reviewed

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SNT allowable cost route rate is multiplied by the units of service to determine allowable reimbursement for SNT services for the year. This amount is then compared to accumulated interim payments for a determination of over or underpayment for SNT services.
Once the determination of (over)/under payment has been made as part of the annual desk review process, a letter informing the staff at SDE of cost settlement results is released. Coincident with the letter release is the release of either a credit adjustment to pay SDE for any underpayment due or the establishment of a DHHS receivable in order to collect any overpayment made to the provider.
The Special Needs Transportation reimbursement methodology described above will end effective September 30, 2012.

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

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.