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Frequently Asked Questions (FAQ): DDSN Transition to Medicaid Direct Billing

Section 1: Rates—Development & Assumptions

Q. 1.1: How were the 2.5% cost-of-living adjustment (COLA) and the 3.4% rate increase obtained by the South Carolina Department of Disabilities and Special Needs (DDSN) in the FY22 state budget incorporated in the rates published by the South Carolina Department of Health and Human Services (SCDHHS) to start Jan. 1, 2022?

Answer: Prior to July 1, 2021, the aggregate rate paid by SCDHHS to DDSN for Intellectual Disability and Related Disabilities (ID/RD) daily residential habilitation (DRH) services amounted to $196.99. Due to the funding received by DDSN from the South Carolina General Assembly during state fiscal year (SFY) 2022, this rate was increased to $204.78 for services provided on and after July 1, 2021.

To develop ID/RD DRH service waiver rates effective Jan. 1, 2022, SCDHHS first determined an aggregate DRH unit cost rate based upon the SFY 2019 DDSN Medicaid Cost Report. During this exercise, the Head and Spinal Cord Injury (HASCI) and ID/RD DRH service costs and units were combined to establish one aggregate unit cost for DRH services. Other adjustments were made to the SFY 2019 DRH services aggregate unit cost rate to take into account the following items: (1) an adjustment downward in order to exclude DDSN central office costs; (2) an adjustment upward in order to include the last of the direct care worker pass-through for SFY 2020 which was not reflected in the SFY 2019 Medicaid cost report; and, (3) a trend rate of 7.32% was applied during the development of the SFY 2019 DRH unit cost rate in order to trend the base year unit cost (i.e. SFY 2019) to the midpoint of the payment period (i.e. calendar year 2022). The trend rate of 7.32% accounts for the COLA increase provided effective July 1, 2021. Therefore, the aggregate DRH unit cost rate effective Jan. 1, 2022, amounts to $221.99. This aggregate cost-based DRH unit cost rate of $221.99 was used as a benchmark rate to test the reasonableness of the 8-tiered DRH service rate computations.

To develop the 8-tiered DRH service rates, SCDHHS employed its contracting actuary to develop the rates. Data supplied by DDSN, DSN Boards and private providers were used to develop assumptions used by the actuaries to model these rates using current salary and projected worker hours required for each tier. Based upon the assumptions used to generate the 8-tiered service rates for the DRH services and data supplied by DDSN regarding the total number of projected units per tier, the aggregate DRH unit rate of the 8-tiered service rates amounts to $226.71.

Q. 1.2: Do the rates include a factor for expected health and retirement cost increases during SFY20, SFY21 and SFY22 (since 2019 data was used for baseline) to providers that are required participants in the state health and state retirement systems?

Answer: Yes. A trend rate of 7.32% was applied during the development of the SFY 2019 DRH unit cost rate in order to trend the base year unit cost (i.e. SFY 2019) to the midpoint of the payment period (i.e. calendar year 2022).

Q. 1.3: Is there a capital component included in the rate for major repairs to facilities/homes? If so, what number/percentage was utilized?

Answer: Yes. In the calculation of the aggregate benchmark DRH unit cost rate of $221.99, any actual repair and capital related costs (i.e. depreciation, rent, interest) incurred by the DSN Boards during SFY 2019 were included in the SFY 2019 Medicaid cost report and thus included in this benchmark rate. In the calculation of the 8-tiered service rates, which reflected an aggregate DRH service rate of $226.71, an indirect cost rate of 10% was applied to account for all indirect costs associated with this service.

Q. 1.4: Is there a component in the rate for staff onboarding and ongoing training? If so, what number/percentage was utilized?

Answer: Yes. In the calculation of the aggregate benchmark DRH unit cost rate of $221.99, any onboarding and training costs incurred by the DSN Boards during SFY 2019 were included in the SFY 2019 Medicaid cost report and thus included in this benchmark rate. In the calculation of the 8tiered service rates, which reflected an aggregate DRH service rate of $226.71, the onboarding and training cost assumptions used by the actuaries were determined by staff level and ran from a low of 20 hours per year (Intensive Behavioral Interventionist) to a high of 53 hours per year (Direct Care Worker).

Q. 1.5: What are the attendance requirements for state-funded residential individuals?

Answer: DDSN intends to mirror the final SCDHHS leave day policy.

Q. 1.6: **Regarding Admissions:**

- **Are there changes to the Critical Needs List process?**
    - **Answe**r: Yes. Forms are updated to reflect both tiers and capitated payment until go-live date.
- **Is there discretion over admission and discharge of individuals?**
    - **Answer:** Yes, but providers have duties regarding transfer to a new setting and have obligations for adherence to residential lease agreements.

Q. 1.7: What vacancy rate assumption (%) was used in the rate development?

Answer: A 2% vacancy rate assumption was used.

Q. 1.8: How were costs associated with staffing for individuals not attending congregate day service settings?

Answer: In the calculation of the aggregate benchmark DRH unit cost rate of $221.99, the staffing costs associated with individuals choosing to stay home or with inappropriate behaviors relating to day program attendance that were incurred by the DSN Boards during SFY 2019 were included in the SFY 2019 Medicaid cost report and thus included in this benchmark rate calculation. No adjustment was made to allowable Medicaid reimbursable costs to remove this cost from the aggregate benchmark DHR unit cost rate. In the calculation of the 8-tiered service rates, which reflected an aggregate DRH service rate of $226.71, no adjustment was made to reduce costs associated with staffing relating to individuals choosing to stay home or with inappropriate behaviors relating to day program attendance.

Q. 1.9: What are public notice requirements for changes to the waiver?

Answer: The waiver renewal application was posted for public comment and a summary of comments/responses was included in the waiver application submitted to the Centers for Medicare and Medicaid Services (CMS). Through the waiver approval process, updates to the waiver application based on feedback from CMS are made. In addition to the public notice period, provider input was collected from focus groups, a provider survey and ongoing dialogue with provider associations. Providers can also submit questions and comments to the MedicaidWaiver@scdhhs.gov email address.

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Section 2: Rates—Attendance

Q. 2.1: What are the rules associated with billing a residential habilitation service unit? For example, what if a residential individual is present for most of the day but is picked up at night? Can that day be billed?

Answer: Current procedures on reporting attendance for residential habilitation are located in the DDSN Finance Manual (chapter 10). The billing procedures for residential habilitation are currently being evaluated and updated policy will be shared once it has been finalized.

Q. 2.2: Is there a mandatory day program attendance?

Answer: No.

Q. 2.3: A big concern I have is related to hospitalizations (incl. rehab). If these residences are really homes, then providers should not have to worry about being paid when an individual is hospitalized – sometimes for long periods. They should not feel forced to terminate a hospitalized individual from a home so that they can move someone else in for payments to be resumed.

Answer: SCDHHS is currently developing a leave policy and will share this policy with all interested parties once it has been finalized.

Updated Jan. 7, 2022: SCDHHS and DDSN will continue to utilize the current leave day amounts, which provides for a maximum of 73 leave days (20%) during a service plan year. Updates to reflect this policy will be made to the waiver policy manuals, residential habilitation service standards, and finance manual as appropriate. Exceptions for an individual incurring leave days in excess of 73 days during a service plan year may be submitted to DDSN for approval. The exception request should include the individuals name, number of leave days associated with each "leave event," a description of the leave event, and the anticipated number of additional leave days requested.

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Section 3: Rates—Case Management

Q. 3.1: What is the case management rate going to be?

Answer: Effective Jan. 1, 2022, the waiver case management (WCM) rates will be as follows: WCM with travel- $27.28 per 15-minute unit, WCM without travel- $16.77 per 15-minute unit.

Q. 3.2: Will that rate be for both Community Supports waiver (CS) and ID/RD? If it is only for ID/RD, when will the rate be changed for CS?

Answer: Yes, the WCM rates will be the same in the CS, ID/RD and HASCI waivers. SCDHHS is currently seeking approval from CMS to transition WCM rates for CS and HASCI effective Jan. 1, 2022.

Q. 3.3: Will case management agencies be direct billing beginning in January 2022? If so, will that just be for the waivers or for Medicaid Targeted Case Management (MTCM), as well?

Answer: SCHHS has targeted a go-live date for direct billing to occur in March 2022 to fully transition provider direct fee-for-service (FFS) billing. During the transition period, which will occur from Jan. 1, 2022, until the go-live date, DDSN will pay providers in the same manner in which DDSN is currently paying providers. The transition to direct billing is for waiver services.

Q. 3.4: In the ID/RD renewal as submitted by SCDHHS, there are more than 13 rates listed that increase over the next five years. Case management is one of them. As the SCDHHS budget is approved, will these rates be rolled out on schedule? Or are there other factors that could come into play to prevent this schedule from taking effect? For long-range planning purposes, it would be helpful for providers to know what to expect.

Answer: For waiver submission purposes, states attempt to address anticipated rate increases as well as changes in Medicaid utilization over the five-year waiver period. While it is the intention of the SCDHHS to update waiver rates annually, two things must occur. First, cost report data must be reviewed to determine whether waiver rates can/need to be increased. Secondly, the South Carolina General Assembly must provide the state matching funds needed to fund the rate increases. The rates reflected in the ID/RD waiver document for each of the five-year rate periods are not guaranteed and will only occur if the two requirements previously listed are met.

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Section 4: Rates – Leave Day Policy

Q. 4.1: Can I bill when a participant "leaves" the residence to visit family?

Answer: SCDHHS is currently developing a leave policy and will share this policy with all interested parties once it has been finalized.

Q. 4.2: If individuals frequently leave the residence for non-medical appointments and/or visits, will we be allowed to charge the individual a "bed hold fee" equivalent to the daily rate after a certain number of vacant days per year.

Answer: No, this is not allowed. Payment by SCDHHS to a provider for services rendered to a Medicaid beneficiary, plus any co-payment required by SCDHHS to be paid by the Medicaid beneficiary, shall constitute payment in full for the service(s) provided.

Updated Jan. 7, 2022: SCDHHS and DDSN will continue to utilize the current leave policy, which provides for a maximum of 73 leave days (20%) during a service plan year. Updates to reflect this policy will be made to the waiver policy manuals, residential habilitation service standards, and finance manual as appropriate. Exceptions for an individual incurring leave days in excess of 73 days during a service plan year may be submitted to DDSN for approval. The exception request should include the individuals name, number of leave days associated with each "leave event," a description of the leave event, and the anticipated number of additional leave days requested.

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Section 5: Residential Tiers

Q. 5.1: What is the current formula/criteria for determining what tier an individual is in?

Answer: Individuals receiving residential services were mapped to the new residential tiers based on the definitions outlined in the ID/RD waiver document, previous funding band assignment, and location of services. General mapping of band to tier is included below. DDSN is currently analyzing the initial mapping to identify unique situations that may require further review. DDSN will inform provider agencies of assignments and will ensure providers have an opportunity to identify any problematic areas.

DDSN Current Residential Capitated/Bundled Rate Waiver Services (15 Total Service Settings)	New Individual Residential Waiver Services with Individual Rates (8 Total Service Settings)	New IDRD Waiver Renewal Individual Residential Rates
3-Person Group Home: High Management	3-Person Group Home: High Management	$427.93
4-Person Group Home: Forensic/Criminal Offender (22)	4-Person Group Home: Tier 4	$364.38
4-Person Group Home: High Management (Band 21)	4-Person Group Home: Tier 3	$308.36
4-Person Group Home: Depop-Residential (Band R)		
4-Person Group Home: "H+" (Band H + Built-In Outlier)		
4-Person Group Home: High Needs (Band H)	4-Person Group Home: Tier 2	$263.55
4-Person Group Home: Low Needs (Band G)	4-Person Group Home: Tier 1	223.55
High Needs SLP II aka SLP III (Band W)	SLP II	$91.84
Low Needs SLP II (Band C)		
CTH I Enhanced (Band F)	CTH I Tier 2	$112.43
CTH I Non-Enhanced (Band E)	CTH I Tier 1	$81.75
Therapuetic Family Homes III (former SFH) [to be discontinued]	CTH I Tier 2	$112.43
Therapuetic Family Homes II (former SFH) [to be discontinued]	CTH I Tier 2	$112.43
Therapuetic Family Homes I (former SFH) [to be discontinued]	CTH I Tier 1	$81.75
CIRs [to be discontinued]	Merge into SLP II	$91.84
	Merge into 4-Person Group Home Tier 1	$223.55

Q. 5.2: How will outlier rates be handled? Will the outlier rate process still exist? Are there criteria for qualifying an individual to receive an outlier rate?

Answer: SCDHHS will not establish an outlier payment process. The development of the 8-tiered DRH service rates will allow providers the opportunity to place the individual in the necessary rate tier based upon the needs of the individual.

Updated Jan. 7, 2022: There will be a protocol to address limited circumstances that require supports beyond the 8-tiered DRH service rates. This will be coordinated between DDSN, SCDHHS, the individual being supported and the provider. The cost of waiver services must remain within cost-neutrality requirements (e.g., the average per capita expenditures for covered HCBS services will not exceed 100% of the average per capita expenditures that would have been made for the level of care provided in an institution).

Q. 5.3: What is the appeal process if we believe a tier is incorrect for an individual? How is an individual notified of a reduction in services?

Answer: If a tier assignment is being appealed, the provider will follow the DDSN reconsideration process. If the reconsideration decision results in a change to the tier, SCDHHS will be notified of the final reconsideration decision, adjust the tiered rate appropriately (if necessary) and recalculate the amount due to the provider. If the final appeal decision from DDSN results in no change to the tier, then the provider should follow the SCDHHS appeals process. Any adverse decision or action related to receipt of services requires written notification to the applicant which is provided by the waiver case manager.

Q. 5.4: How were the residential tiers developed?

Answer: Input was submitted from DDSN on the current structure for residential services and the proposed "new" tiered residential services. DDSN leadership reviewed other states' models, identified best practice frameworks, and used present day band assignments and residential settings with an emphasis on staff to individual served ratios, which were provided by DSN Boards and private providers.

Q. 5.5: Where does Supported Living Program I (SLP I) fall in the tiers?

Answer: SLP I is a residential habilitation service that is billed as a 15-minute unit rate.

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Section 6: Provider Enrollment and Billing

Q. 6.1: What are the dates for provider enrollment training?

Answer: A provider enrollment training took place on Dec. 16, 2021, from 2-3 p.m. and Dec. 21, 2021, from 10-11 a.m. Notification with updated registration links was sent via email to providers on Dec. 8, 2021. A recorded version of the webinar is now available on the SCDHHS website.

Q. 6.2: Do we need a single Medicaid provider number that can be used for all services or do we apply for a provider number for each waiver service?

Answer: A single Medicaid provider number will be issued for each provider (not for each waiver service). Providers that are currently enrolled as early intervention (EI) providers will still need to complete an application and enroll as a waiver provider.

Q. 6.3: What documentation will be required to support billing? Will a data collection tool be developed?

Answer: This will be addressed in future provider training sessions for billing.

Updated Feb. 25, 2022: Training modules on the billing process are available on the SCDHHS transition to direct billing website.

Q. 6.4: After the transition to fee-for-service, will room and board approvals still be required?

Answer: Room and board is not an allowable Medicaid cost; however, these reports will still be required. DDSN has an affirmative responsibility to oversee and safeguard our vulnerable individuals' resource expenditures, of which room and board is most significant.

Updated Feb. 25, 2022:

Q. 6.5: If I am billing for services that are not the same as primary taxonomy, which one do I use?

Answer: Use the primary taxonomy and National Provider Identifier (NPI) number that was on your enrollment application when completing claims.

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Q. 6.6: How do I bill for leave days for residential habilitation?

Answer: Complete the claim using the residential habilitation procedure code and appropriate modifier for the tier of service. Use "LV" as a second modifier. This must be in the second modifier position.

Q. 6.7: What are the key days/cut-off days for claims processing?

Answer: Best practice is to submit claims by close of business Friday. Claims process on Monday, remittance advice is available on Wednesday and payment occurs on the following Friday for approved claims.

Q. 6.8: When will the transition of payment from DDSN to SCDHHS occur?

Answer: Dates of service prior to Apr. 1 will be paid by DDSN. Dates of service on or after Apr. 1 will be billed to and paid by SCDHHS.

Q. 6.9: How will diagnosis codes be entered?

Answer: SCDHHS Web Tool users should enter the diagnosis code on the claim. Diagnosis codes are included in the Therap billing module and do not need to be entered manually. Providers should use the diagnosis code that is in Therap, regardless of which billing method is used.

Q. 6.10: When and how will I receive my SCDHHS Web Tool login credentials?
Answer: This should be received via email. It generally takes 10 days from the application approval date to receive login credentials for the SCDHHS Web Tool.

Q. 6.11: Who do I contact with questions regarding login credentials for the SCDHHS Web Tool?

Answer: Questions on Web Tool access can be directed to the SCDHHS Provider Service Center Electronic Data Interchange (EDI) support team at (888) 289-0709, option #1.

Q. 6.12: Do I need to fax in a copy of my DDSN contract?

Answer: Yes, a copy of the contract needs to be faxed in at the time the online enrollment application is completed. Failure to fax in the contract will result in delays in application processing times. A copy of the contract is required to complete the enrollment application.

(End of FAQ)