DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Atlanta Regional Office
61 Forsyth Street, Suite 4T20
Atlanta, Georgia 30303

CENTERS FOR MEDICARE & MEDICAID SERVICES

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

August 16, 2018

Mr. Joshua Baker
Director
SC Department of Health and Human Services
Post Office Box 8206
Columbia, South Carolina 29202-8206

Attention: Sheila Chavis

RE: Title XIX State Plan Amendment, SC 12-026

Dear Mr. Baker:

We have reviewed the proposed State Plan Amendment, SC 12-026, which was submitted to the Atlanta Regional Office on December 21, 2012. This amendment was submitted to eliminate retrospective cost settlements and establish prospective payment rates effective October 1, 2012 for Mental Health Clinic services, Special Needs Transportation services, Family/Early Intervention services, and Preventive Services for Primary Care Enhancement services.

Based on the information provided, the Medicaid State Plan Amendment SC 12-026 was approved on August 16, 2018. The effective date of this amendment is October 1, 2012. We are enclosing the approved HCFA-179 and the plan pages.

If you have any additional questions or need further assistance, please contact Cheryl Wigfall at (803) 252-7299.

Sincerely,

Shantrina D. Roberts, MSN
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: SC 12-026

2. STATE: South Carolina

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
October 1, 2012

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR Part 440

7. FEDERAL BUDGET IMPACT: Rates are projected to approximate allowable Medicaid costs.
a. FFY 2013 $0
b. FFY 2014 $0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-B, Pages 0a, 2, 2.1, 2a, 2a.1, 3a.2, 3a.3, 3a.4, 3a.5, 6, 6h, 6h.1, 6h.2,6h.3

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Attachment 4.19-B, Pages 0a, 2, 2.1, 2a, 2a.1,3a.2, 3a.3, 3a.4, 3a.5, 6, 6h, 6h.1, 6h.2,6h.3

10. SUBJECT OF AMENDMENT:
Elimination of retrospective cost settlements and establishment of prospective payment rates effective 10/1/12 for: MH clinic services, Special Needs Transportation; Early Intervention Service; Preventive Services for Primary Care Enhancement.

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Mr. Keck was designated by the Governor to review and approve all State Plans

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Anthony E. Keck

14. TITLE:
Director

15. DATE SUBMITTED:
December 18, 2012

16. RETURN TO:

South Carolina Department of Health and Human Services
Post Office Box 8206
Columbia, SC 29202-8206

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 12/21/12

18. DATE APPROVED: 08/16/18

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
10/01/12

20. SIGNATURE OF REGIONAL OFFICIAL:
Wanda Kimble for

21. TYPED NAME:
Shantrina D. Roberts

22. TITLE: Associate Regional Administrator
Division of Medicaid & Children's Health Operations

23. REMARKS: Approved with the following changes to blocks 8 and 9 as authorization by state agency on emails dated 03/16/18 and 08/15/18.

Block # 8 changed to read: Oa, 2, 2.1, 2.a1, 2.a1.1, 3a.2 3a.3, 3a.4, 3a.5, 6, 6.1e, 6.2, 6h, 6h.1, 6h.2 and 6h.3

Block # 9 changed to read: Oa, 2, 2.1, 2.a1, 3a.2 3a.3, 3a.4, 3a.5, 6, 6.1e, 6.2, 6h, 6h.1, 6h.2 and 6h.3, 6.1f remove from the state plan

Medicaid SP Section 419-B (Reimbursement) Review

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

3. Other Laboratory and X-Ray Services:

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

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. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The agency's fee schedule rate was set as of July 11, 2011 and is effective for services provided on or after that date. All rates are published on the agency's website at www.scdhhs.gov.

Comprehensive Health and Developmental History including
Assessment of both Physical and Mental Health Development

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

Optional services as deemed medically necessary by the provider:

Lead Screening	Tuberculin Skin Test	Urinalysis
Sickle Cell Test	Parasite Test	

Immunizations:

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

Payments for EPSDT Services that are not otherwise covered:

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

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

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

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

Early Intervention/Family Training Services and Sign Language Services

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

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

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

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

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

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

Direct Costs:

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

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

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

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

Supervision:

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

Indirect Costs:

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

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

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

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

Home Based Private Duty Nursing Services:

Home Based Private Duty Nursing reimbursement rates are separately established for Registered Nurses (RN) and Licensed Practical Nurses (LPN). Salaries, fringe benefits, limited direct, and indirect costs are considered in the development of the rates. Services are billed in 6-minute increments; therefore, ten (10) units equate to an hour of care. (In the instances of private duty nursing services to Department of Disabilities and Special Needs (DDSN) clients under 21, these services are billed in fifteen (15) minute increments.) Except as otherwise noted in the plan, the state-developed fee schedule rates are the same for both governmental and private providers of home based private duty nursing services. The agency's fee schedule rate was set as of July 11, 2011 and is effective for services provided on or after that date. All rates are published on the agency's website at www.scdhhs.gov.

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

Personal Care Services:

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

Freestanding and hospital based certified ESRD clinics are reimbursed using the methodology described in this section. However, outpatient hospital dialysis services are billed on the UB claim form and reimbursed under the outpatient hospital payment methodology described in section 2a of Attachment 4.19-B.The all inclusive fee is based on the statewide average of the composite rates established by Medicare. ESRD fee schedules and updates are published in the ''Clinic Services Provider Manual'' and are the same for governmental and private providers of this service. Payment to free standing ESRD clinics is 96 percent of the 2003 Medicare Fee Schedule. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The agency's fee schedule rate was set as of July 11, 2011 and is effective for services provided on or after that date. All rates are published on the agency's website at www.scdhhs.gov. See page 0a of Attachment 4.19-B.

Mental Health Clinics

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

MEDICAID BILLABLE SERVICES (Community Mental Health Clinics):

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

Services and Approved Abbreviation	Procedure Code	Unit Time	Maximum Units/Day
Behavioral Health Screening - Alcohol/Drug	H0002 HF	15 minutes	2
Crisis Intervention Service (CI)	H2011	15 minutes	20
Family Therapy, client not present	90846	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

Effective for services provided on or after October 1, 2012, state owned governmental providers of community mental health clinic services will receive prospective payment rates based upon its 2010 fiscal year end Medicaid cost report. In order to trend the cost of each service to the initial payment period of October 1, 2012 through June 30 2013, the Medicaid Agency will employ the midpoint to midpoint methodology and the use of the CY 2010 Medicare Economic Index (1.2%). State owned governmental providers of community mental health clinic services will be required to submit annual cost reports when certified public expenditures are used as the source of state matching funds.

Interim Rates

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

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

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

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

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

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

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

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

Direct Costs:

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

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

Supervision:

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

Indirect Costs:

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

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

Settlement Procedures (Community Mental Health Providers):

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

Outpatient Pediatric Aids Clinics

Outpatient Pediatric Aids Clinics (OPACs) provide specialty care, consultation and counseling services for HIV-infected and exposed Medicaid children and their families. OPACs provide services that are medical, behavioral, psychological and psychosocial in nature. 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 Medicare reasonable cost principles and criteria outlined under 45 CFR Part 75 and 42 CFR Part 413.

Direct Costs:

1) Personnel costs – Expenditures from the accounting records of the 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,

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

13.c Preventive Services

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

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

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

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

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

Preventive Services - Disease Management

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

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

Total Allowable Costs by service by practitioner:

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

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

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

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

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

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

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

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

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

17. Nurse Midwife Services:

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

18. Hospice Services:

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. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The agency's fee schedule rate was set as of July 11, 2011 and is effective for services provided on or after that date. All rates are published on the agency's website at www.scdhhs.gov.

In addition to the four reimbursement rates of the services described below, Hospice providers are also required to reimburse nursing facilities and ICF/ID 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 intellectually disabled. Effective October 1, 2008, the Hospice Agency is responsible for reimbursing nursing facilities and intermediate care facilities for the intellectually disabled 98% of the daily room and board rate.

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

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

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

24.a Transportation:

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

B. Non-Broker Transportation Services:

Emergency Ambulance Services: Payment for emergency ambulance services will be the lesser of actual charges submitted by the carrier or the ceiling of the fees established by SCDHHS and published in the Ambulance Services Provider Manual. The fee schedule for ambulance services is inclusive of all supplies required during transportation to include EKG/DEF, airways, oxygen, and field drugs. The fee schedule will be applied uniformly without consideration of locality. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers. For the covered Medicaid emergency ambulance services that have a comparable Medicare rate, the Medicaid fee payments will not exceed the payments calculated at one hundred percent of the Medicare Fee Schedule (in the aggregate). The agency's fee schedule rate was set as of July 11, 2011 and is effective for services provided on or after that date. All rates are published on the agency's website at www.scdhhs.gov.

Special Needs Transportation:

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

Description and Discussion of Cost Finding for SNT:

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

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

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

School Districts' Direct Costs:

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

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

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

State Department of Education (SDE) Direct Costs:

1. The costs incurred by the SDE related to the purchase and maintenance of equipment for statewide student transportation are identified. Costs included here include maintenance salaries and fringes, supplies, purchased services and other expenses associated with maintaining the statewide fleet of buses. This includes all costs associated with the operation of 44 bus shops statewide to include fuel purchases, parts and repairs, shop supplies, and insurance.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.

2. State Department of Education costs as defined above are accumulated (net of allowances for capital items) for the determination of the statewide rate. The SDE's indirect cost rate is applied to reflect the indirect support of SDE provided to the Office of Transportation services.

Application of Use Allowances for Capital Items:

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

Total Transportation Cost Pool:

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

Distribution of Cost Pool:

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

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

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

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

Utilization Data and Determination of Special Needs Route Rate:

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

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

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

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

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

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

Other Types of Transport Services (Non-Brokered):

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

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

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

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

State Agency and School District Providers:

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