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State/Territory Name: SC

State Plan Amendment (SPA) 22-0001

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
233 North Michigan Ave., Suite 600
Chicago, Illinois 60601

Financial Management Group

May 4, 2022

Mr. Robert M. Kerr, Director
South Carolina Department of Health & Human Services
P.O. Box 8206
Columbia, South Carolina 29202-8206

Attention: Sheila Chavis

RE: South Carolina State Plan Amendment (SPA) 22-0001

Dear Mr. Kerr:

We have reviewed the proposed South Carolina State Plan Amendment (SPA) 22-0001, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on March 23, 2022. This SPA will increase rates for certain incontinence supplies, Substance Abuse and Addictive Disorder services, autism spectrum disorder (ASD) services, and peer support services.

Based upon the information provided by the State, we have approved the amendment with an effective date of January1, 2022. We are enclosing the approved CMS-179 and a copy of the new state plan pages.

If you have any additional questions or need further assistance, please contact Moe Wolf at 410-786-9291 or Moshe.Wolf@CMS.HHS.gov.

Sincerely,

Todd McMillion

Todd McMillion
Director
Division of Reimbursement Review

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 22-0001

2. STATE: SC

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

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: January 1, 2022

5. FEDERAL STATUTE/REGULATION CITATION: 42 CFR Part 447

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2022 $ 5.625.000
b. FFY 2023 $ 7,500,000

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-B pages, 2.1.1, 3a, 6.1e.c, 6.1e.e (new page)

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Attachment 4.19-B pages, 2.1.1, 3a, 6.1e.c

9. SUBJECT OF AMENDMENT

This SPA will increase rates for certain incontinence supplies,Substance Abuse & Addictive Disorders, ASD,& Peer Supports svcs

10. 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:

11. SIGNATURE OF STATE AGENCY OFFICIAL

12. TYPED NAME: Robert M. Kerr

13. TITLE: Director

14. DATE SUBMITTED: March 30, 2022

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

FOR CMS USE ONLY

16. DATE RECEIVED: March 23, 2022

17. DATE APPROVED: May 4, 2022

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL: January 1, 2022

19. SIGNATURE OF APPROVING OFFICIAL: Todd McMillion

20. TYPED NAME OF APPROVING OFFICIAL: Todd McMillion

21. TITLE OF APPROVING OFFICIAL: Director, DRR

22. REMARKS

Applied Behavior Analysis

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

Effective January 1, 2022, the following ABA codes were increased by thirty percent (30%) in order to improve the provider network based upon recent market rate comparisons (97153,97155, and 97156). All rates are published on the SCDHHS public website.

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

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

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

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. Effective for dates of service on or after January 1, 2022, the rates for incontinence supplies billed using Healthcare Common Procedure Coding System (HCPCS) codes A4554, T4521, T4522, T4523, T4524, T4525, T4526, T4527, T4528, T4529, T4530, T4531, T4532, T4533, T4534, T4535, T4543, and T5999 will increase by ten percent(10%). 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 January 1, 2022. 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:

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. Effective January 1, 2022, rates for procedure codes H0011 and H0015 were increased by fifteen percent (15%) to take into account inflationary trends. 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

Effective January 1, 2022, rates for procedure codes H0001 and H0004 were increased by fifteen percent (15%) to take into account inflationary trends. Effective January 1, 2022, procedure code H0038 will increase to $10.74, and the group code modifier (HQ) will increase to $1.79.