SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

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MEDICAID BULLETIN

TO: **All Providers**

SUBJECT: **July 1 Coverage and Reimbursement Changes**

The South Carolina Department of Health and Human Services (SCDHHS), in its continuing efforts to purchase the most health for our citizens at the least possible cost to the taxpayer, routinely evaluates the services provided through the South Carolina Healthy Connections Medicaid program and the related provider payments issued for delivering those services. As a result of these efforts, several benefit and reimbursement changes are being implemented on July 1, 2019. While much of this information has been announced through other avenues, this bulletin reflects an effort to provide a comprehensive account. More details related to these changes are available at the SCDHHS website and in the Medicaid Provider Guides at www.scdhhs.gov.

Pediatric and Preventative Benefit Enhancements

Over recent years, SCDHHS has engaged in a number of efforts to ensure that the Medicaid benefit, especially as it relates to preventative and pediatric care, is consistent with evidence-based standards. These include considerable investments in quality of care through the Birth Outcomes Initiative (BOI) and Quality Through Innovation in Pediatrics (QTIP) program, and expanded access to immunizations and pediatric screenings.

In a continued effort to ensure the provision of the high-quality, evidence-based care, SCDHHS is adding coverage of the following services to the Medicaid benefit:

- Well-child visits on the same day as sick-child visits for beneficiaries from birth to age 21, using modifier "25."
- Continuous glucose monitoring (CGM) for individuals with type 1 diabetes or insulin-dependent gestational diabetes.
- Breast Cancer Susceptibility Gene 1 and 2 (BRCA) testing for those who meet medical necessity criteria, as defined by the National Comprehensive Cancer Network (NCCN) Clinical Practice Guidelines in Oncology – Genetic/Familial High-Risk Assessment.

CGM and BRCA will require prior authorization (PA) for fee-for-service (FFS) beneficiaries. More information on these benefits, including instructions on obtaining a PA through KEPRO, are available in the Physician Services Provider Guide, available at www.scdhhs.gov.

PA requirements for managed care organizations (MCOs) may vary. Contact the MCO in which the beneficiary is enrolled for specific information on coverage and prior authorization requirements.

Reimbursement Methodology Modernization

In 2018, SCDHHS began an effort to systematically evaluate the reimbursement methodologies used to establish rates for Medicaid providers to align with the market and more accurately reflect the underlying cost of providing care. Over the first year, this project has focused on reimbursement for physician, advance practice, durable medical equipment (DME), and autism spectrum disorder (ASD) providers. An evaluation of the SCDHHS reimbursement approach for other providers is scheduled for future phases of this effort.

As a result of this project, effective July 1, 2019:

- *Physician and advance practice providers.* SCDHHS will transition from the 2009 to the 2019 Medicare fee schedule as a basis for determining Medicaid reimbursement for physicians.
    - Base Medicaid rates will be set at 78% of the Medicare fee schedule for evaluation, preventative care and diagnostic services, and at 71% for of the Medicare fee schedule for all other services.
    - Providers who currently participate in the Enhanced Physician Fee Schedule program will be reimbursed at 129% of the base Medicaid rate.
    - Neonatologists and pediatric subspecialists will be reimbursed at 140% of the base Medicaid rate.
    - Advance practice providers will be reimbursed at 80% of the base Medicaid rate.
- *DME providers.* Reimbursement for DME, where the rate is determined based on Medicare rates, will be updated to 100% of the 2019 Medicare Durable Medical Equipment, Prosthetics/Orthotics and Supplies (DMEPOS) non-rural fee schedule. Rates not based on the Medicare rates, including respiratory and enteral nutrition services, will remain at the current rate.
- *ASD Providers.* The reimbursement rates for adaptive behavior treatment by protocol (97153) will increase to $8.64 per 15-minute unit ($34.56 per hour). The rate for adaptive behavior treatment with protocol modification (97155) will increase to $15.74 per 15-minute unit ($62.96 per hour). The rate for family adaptive behavior treatment guidance (97156) will increase to $15.74 per 15-minute unit ($62.96 per hour).

The rates and methodologies reflected in this section apply to services provided to FFS Medicaid beneficiaries. Reimbursement for beneficiaries enrolled in MCOs are governed by the contractual relationship between each MCO and its providers. Questions regarding MCO reimbursement should be directed to the MCO in which the beneficiary is enrolled.

Managed Care Carve-In for Inpatient Psychiatry and Opioid Treatment Programs

In July 2016, SCDHHS began a transition of behavioral health services from the FFS Medicaid program to the managed care benefit. To complete this transition and facilitate coordination across the entire continuum of care for behavioral health and substance use disorder (SUD) treatment, SCDHHS will include coverage for the following services in the managed care benefit for beneficiaries who are enrolled in an MCO:

- Inpatient psychiatric care for children delivered in institutions for mental diseases (IMDs).
- SUD services provided in opioid treatment program (OTP) clinics.

340B Reimbursement

SCDHHS has identified the need to more accurately identify claims for drugs purchased through the 340B program to ensure the appropriate treatment of these claims related to Medicaid rebates. Pharmacy providers billing the FFS benefit must submit a value of "20" in the Submission Clarification Code field (42Ø-DK) for 340B drugs. Providers should continue to submit the actual acquisition cost of the medication, plus a 340-dispensing fee of $10.50, as the usual and customary charge.

Guidance issued by the Health Resources and Services Administration (HRSA), provides additional restrictions on the use of drugs purchased under the 340B program for Medicaid beneficiaries when they are dispensed by contract pharmacies. Specifically, HRSA requires that the covered entity, the contract pharmacy and the state Medicaid agency have an arrangement to prevent duplicate discounts, with that arrangement being reported to HRSA. As no such arrangements exist for the South Carolina Healthy Connections Medicaid program, contract pharmacies must carve-out Medicaid beneficiaries.

Dental Benefit Alignment

To ensure alignment with standards of care and Early Periodic Screening, Diagnostic and Treatment (EPSDT) requirements, SCDHHS is updating the Medicaid dental benefit, effective July 1, 2019, as follows:

- Bilateral fixed space maintainers are allowed and reimbursable when there is no service history of any space maintainers for the same arch or a service history of one unilateral fixed space maintainer.
- Resin-based composite crowns for anterior teeth will be allowed for Medicaid beneficiaries under the age of 21 and for Intellectual Disability/Related Disabilities (ID/RD) Waiver participants.
- Pre- and post-treatment radiographs must be included with the documentation submitted for pre-payment review of endodontic procedures.
- Claims for an initial dental encounter within the first 30 days of entry into foster care must include:
  - A check in the EPSDT box in field 1 of the ADA claim form; **AND,**
  - An indication of "FOSTER CARE" in the remarks field #35 of the ADA claim form or in the notes field when filing claims electronically.

Please refer any questions or concerns regarding this bulletin to the Healthy Connections Provider Service Center at (888) 289-0709.

Thank you for your continued support of the South Carolina Healthy Connections Medicaid program.

/s/
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