DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Hess	9-15-11

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 10-123	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR cc: Mr. Keck, Deps, CMS file, SPA file Cleared 10/20/12, letter attached	[X] Prepare reply for appropriate signature DATE DUE 10-31-11 [ ] FOIA DATE DUE _____ [ ] Necessary Action

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
1.			
2.			
3.			
4.			

Department of Health & Human Services
Centers for Medicare & Medicaid Services
61 Forsyth St., Suite 4T20
Atlanta, Georgia 30303-8909

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

September 8, 2011

Mr. Anthony E. Keck
Director
Department of Health and Human Services
P.O. Box 8206
Columbia, South Carolina 29202-8206

RE: South Carolina Title XIX State Plan Amendment, Transmittal #11-018

Dear Mr. Keck:

South Carolina submitted State Plan Amendment (SPA) 11-018, which was received by the Centers for Medicare & Medicaid Services (CMS) on June 24, 2011. This amendment was submitted in response to the SC 11-001 companion letter which was issued on April 4, 2011. The submission of SC 11-018 adds the fee schedule language to Clinical Services and Dental Services.

We conducted our review of SC 11-018 according to federal regulations. Based on our previous conversations, before we can continue processing this amendment, we are requesting additional information as follows:

1. Your cover letter states you provided the standard funding question (SFQ) responses with the submission of SC 11-001. Each SPA submission is a stand alone submission and all pertinent documents must be provided. During the review SC 11-001, SC requested that all concerns outside the initial submission be addressed through the companion letter process therefore the SFQ's were not provided. As part of our review of SC 11-018, we want to ascertain that the funding associated with clinical and dental reimbursement has been appropriately evaluated and is in accordance with federal guidelines.

   Please provide the SFQ's responses as it pertains to dental and clinical reimbursement. The questions are as follows:

   Standard Funding Questions

   1. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by States for services under the approved State plan.

Do providers receive and retain the total Medicaid expenditures claimed by the State (includes normal per diem, supplemental, enhanced payments, other) or is any portion of the payments returned to the State, local governmental entity, or any other intermediary organization? If providers are required to return any portion of payments, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.)

2. Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state share of each type of Medicaid payment (normal per diem, supplemental, enhanced, other) is funded. Please describe whether the state share is from appropriations from the legislature to the Medicaid agency, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either through an IGT or CPE. In this case, please identify the agency to which the funds are appropriated. Please provide an estimate of total expenditure and State share amounts for each type of Medicaid payment. If any of the non-federal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the state agency receives the transferred amounts from the local governmental entity transferring the funds.

If CPEs are used, please describe the methodology used by the state to verify that the total expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b). For any payment funded by CPEs or IGTs, please provide the following:
(i) a complete list of the names of entities transferring or certifying funds;
(ii) the operational nature of the entity (state, county, city, other);
(iii) the total amounts transferred or certified by each entity;
(iv) clarify whether the certifying or transferring entity has general taxing authority: and,
(v) whether the certifying or transferring entity received appropriations (identify level of appropriations).

3. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.

4. For clinic or outpatient hospital services please provide a detailed description of the methodology used by the state to estimate the upper payment limit (UPL) for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated). Please provide a current (i.e., applicable to the current rate year) UPL demonstration.

5. Does any governmental provider receive payments that in the aggregate (normal per diem, supplemental, enhanced, other) exceed their reasonable costs of providing services? If payments exceed the cost of services, do you recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?

2. *4.19B, Page 3a, Section 9. Clinical Services* - The weblink included in the SPA amendment is generic and does not directly link the viewer to the fee schedule associated with clinical services. Please revise the weblink such that when it is opened the fee schedules are visible.

3. *4.19B, Page 3a, Section 10. Dental Services* - The weblinks included in the SPA amendment are generic and do not directly link the viewer to the fee schedules associated with dental services. Please revise the weblinks such that when they are opened, the fee schedules are visible.

We are requesting this additional/clarifying information under provisions of section 1915(f) of the Social Security Act (added by PL 97-35). This has the effect of stopping the 90-day clock for CMS to take action on the material, which would have expired on September 21, 2011. A new 90-day clock will not begin until we receive your response to this request.

In accordance with our guidelines to all State Medicaid Directors dated January 2, 2001, if we have not received the State's response to our request for additional information within 90 days from the date of this letter, we will initiate disapproval action on the amendment.

In addition, because this amendment was submitted after January 2, 2001 and is effective after January 1, 2001, please be advised that we will continue to defer FFP for State payments made in accordance with this amendment until it is approved. Upon approval, FFP will be available for the period beginning with the effective date through the date of approval.

If you have any questions or need any further assistance, please contact Yvette Moore at (404) 562-7327.

Sincerely,

Jackie Glaze

Jackie Glaze
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosure

From: "Moore, Yvette (CMS/CMCHO)" <yvette.moore@cms.hhs.gov>
To: "keck@scdhhs.gov" <keck@scdhhs.gov>
CC: Alicia Jacobs <Jacobs@scdhhs.gov>, Jeff Saxon <Saxon@scdhhs.gov>, Elizab...
Date: 9/12/2011 10:09 AM
Subject: SC 11-018 - Request for Additional Information
Attachments: SC 11-018 RAI.pdf

Good Morning Mr. Keck,

Attached is the formal Request for Additional Information (RAI) for South Carolina SPA 11-018 which was received by the Centers for Medicare and Medicaid Services (CMS) on June 24, 2011. This amendment was submitted in response to the SC -11-001 companion letter which was issued on April 4, 2011. The submission of SC 11-018 adds the fee schedule language to Clinical Services and Dental Services.

You should receive a hard copy in the mail within the next few days. Please note that this RAI stops the 90-day clock. Once the RAI has been answered and the information is received, a new 90-day timeframe begins from that date.

If you have any questions during the interim, please do not hesitate to give me a call.../zym

Z. Yvette Moore, MHA
Region IV Non-Institutional Payment Team (NIPT)
DHHS, Centers for Medicare & Medicaid Services
Sam Nunn Atlanta Federal Center
Division of Medicaid & Children's Health Operations
61 Forsyth Street, SW, Suite 4T20
Atlanta, GA 30303-8909
*: 404-562-7327
7: 443.380.5881
*: yvette.moore@cms.hhs.gov<BLOCKED::mailto:yvette.moore@cms.hhs.gov>

[cid:image001.png@01CC7132.04FA2E70]

Department of Health & Human Services
Centers for Medicare & Medicaid Services
61 Forsyth St., Suite 4T20
Atlanta, Georgia 30303-8909

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

September 8, 2011

Mr. Anthony E. Keck
Director
Department of Health and Human Services
P.O. Box 8206
Columbia, South Carolina 29202-8206

RE: South Carolina Title XIX State Plan Amendment, Transmittal #11-018

Dear Mr. Keck:

South Carolina submitted State Plan Amendment (SPA) 11-018, which was received by the Centers for Medicare & Medicaid Services (CMS) on June 24, 2011. This amendment was submitted in response to the SC 11-001 companion letter which was issued on April 4, 2011. The submission of SC 11-018 adds the fee schedule language to Clinical Services and Dental Services.

We conducted our review of SC 11-018 according to federal regulations. Based on our previous conversations, before we can continue processing this amendment, we are requesting additional information as follows:

1. Your cover letter states you provided the standard funding question (SFQ) responses with the submission of SC 11-001. Each SPA submission is a stand alone submission and all pertinent documents must be provided. During the review SC 11-001, SC requested that all concerns outside the initial submission be addressed through the companion letter process therefore the SFQ's were not provided. As part of our review of SC 11-018, we want to ascertain that the funding associated with clinical and dental reimbursement has been appropriately evaluated and is in accordance with federal guidelines.

   Please provide the SFQ's responses as it pertains to dental and clinical reimbursement. The questions are as follows:

   Standard Funding Questions

   1. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by States for services under the approved State plan.

Do providers receive and retain the total Medicaid expenditures claimed by the State (includes normal per diem, supplemental, enhanced payments, other) or is any portion of the payments returned to the State, local governmental entity, or any other intermediary organization? If providers are required to return any portion of payments, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.)

2. Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state share of each type of Medicaid payment (normal per diem, supplemental, enhanced, other) is funded. Please describe whether the state share is from appropriations from the legislature to the Medicaid agency, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either through an IGT or CPE. In this case, please identify the agency to which the funds are appropriated. Please provide an estimate of total expenditure and State share amounts for each type of Medicaid payment. If any of the non-federal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the state agency receives the transferred amounts from the local governmental entity transferring the funds.

If CPEs are used, please describe the methodology used by the state to verify that the total expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b). For any payment funded by CPEs or IGTs, please provide the following:
(i) a complete list of the names of entities transferring or certifying funds;
(ii) the operational nature of the entity (state, county, city, other);
(iii) the total amounts transferred or certified by each entity;
(iv) clarify whether the certifying or transferring entity has general taxing authority: and,
(v) whether the certifying or transferring entity received appropriations (identify level of appropriations).

3. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.

4. For clinic or outpatient hospital services please provide a detailed description of the methodology used by the state to estimate the upper payment limit (UPL) for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated). Please provide a current (i.e., applicable to the current rate year) UPL demonstration.

5. Does any governmental provider receive payments that in the aggregate (normal per diem, supplemental, enhanced, other) exceed their reasonable costs of providing services? If payments exceed the cost of services, do you recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?

2. *4.19B, Page 3a, Section 9. Clinical Services* - The weblink included in the SPA amendment is generic and does not directly link the viewer to the fee schedule associated with clinical services. Please revise the weblink such that when it is opened the fee schedules are visible.

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We are requesting this additional/clarifying information under provisions of section 1915(f) of the Social Security Act (added by PL 97-35). This has the effect of stopping the 90-day clock for CMS to take action on the material, which would have expired on September 21, 2011. A new 90-day clock will not begin until we receive your response to this request.

In accordance with our guidelines to all State Medicaid Directors dated January 2, 2001, if we have not received the State's response to our request for additional information within 90 days from the date of this letter, we will initiate disapproval action on the amendment.

In addition, because this amendment was submitted after January 2, 2001 and is effective after January 1, 2001, please be advised that we will continue to defer FFP for State payments made in accordance with this amendment until it is approved. Upon approval, FFP will be available for the period beginning with the effective date through the date of approval.

If you have any questions or need any further assistance, please contact Yvette Moore at (404) 562-7327.

Sincerely,

Jackie Glaze

Jackie Glaze
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosure

*This supersedes log #123 w/additional info.

File

Brenda James - Amended request for additional information (RAI) for SC 11-013 & SC 11-013

cc: Mr. Keck
Deps
CMS file
Saxon
Hutto
Vaughn

From: "Moore, Yvette (CMS/CMCHO)" <yvette.moore@cms.hhs.gov>
To: "keck@scdhhs.gov" <keck@scdhhs.gov>
Date: 10/19/2011 12:26 PM
Subject: Amended request for additional information (RAI) for SC 11-013 & SC 11-013
CC: "Glaze, Jackie L. (CMS/CMCHO)" <Jackie.Glaze@cms.hhs.gov>, "Gaskins,Sher...
Attachments: SC 11-013 Amended RAI dated 10192011.pdf; SC 11-018 Amended RAI dated 10192011.pdf

Good Afternoon Director Keck,
Attached are amended RAI requests for SC 11-013 and SC 11-018. These RAI's are being amended to include the appropriate Affordable Care Act (ACA) maintenance of effort (MOE) questions.

The hardcopy will be sent out by U.S. Postal Service today.

Please do not hesitate to give me a call if you have any follow-up questions. Thanks in advance, /Yvette

Z. Yvette Moore, MHA
Region IV Non-Institutional Payment Team (NIPT)
DHHS, Centers for Medicare & Medicaid Services
Sam Nunn Atlanta Federal Center
Division of Medicaid & Children's Health Operations
61 Forsyth Street, SW, Suite 4T20
Atlanta, GA 30303-8909
☎: 404-562-7327
🖷: 312-294-7262
✉: yvette.moore@cms.hhs.gov

Department of Health & Human Services
Centers for Medicare & Medicaid Services
61 Forsyth St., Suite 4T20
Atlanta, Georgia 30303-8909

October 19, 2011

Mr. Anthony E. Keck
Director
Department of Health and Human Services
P.O. Box 8206
Columbia, South Carolina 29202-8206

RE: Amended Request: South Carolina Title XIX State Plan Amendment, Transmittal #11-018

Dear Mr. Keck:

South Carolina (SC) submitted State Plan Amendment (SPA) 11-018, which was received by the Centers for Medicare & Medicaid Services (CMS) on June 24, 2011. This amendment was submitted in response to the SC 11-001 companion letter which was issued on April 4, 2011. The submission of SC 11-018 adds the fee schedule language to Clinical Services and Dental Services.

We conducted our review of SC 11-018 according to federal regulations. Based on our previous conversations, before we can continue processing this amendment, we are requesting additional information as follows:

1. Your cover letter states you provided the standard funding question (SFQ) responses with the submission of SC 11-001. Each SPA submission is a stand alone submission and all pertinent documents must be provided. During the review SC 11-001, SC requested that all concerns outside the initial submission be addressed through the companion letter process therefore the SFQ's were not provided. As part of our review of SC 11-018, we want to ascertain that the funding associated with clinical and dental reimbursement has been appropriately evaluated and is in accordance with federal guidelines.

   Please provide the SFQ's responses as it pertains to dental and clinical reimbursement. The questions are as follows:

Standard Funding Questions

1. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by States for services under the approved State plan.

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2. Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state share of each type of Medicaid payment (normal per diem, supplemental, enhanced, other) is funded. Please describe whether the state share is from appropriations from the legislature to the Medicaid agency, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either through an IGT or CPE. In this case, please identify the agency to which the funds are appropriated. Please provide an estimate of total expenditure and State share amounts for each type of Medicaid payment. If any of the non-federal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the state agency receives the transferred amounts from the local governmental entity transferring the funds.

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4. For clinic or outpatient hospital services please provide a detailed description of the methodology used by the state to estimate the upper payment limit (UPL) for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated). Please provide a current (i.e., applicable to the current rate year) UPL demonstration.

5. Does any governmental provider receive payments that in the aggregate (normal per diem, supplemental, enhanced, other) exceed their reasonable costs of providing services? If payments exceed the cost of services, do you recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?

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Maintenance of Effort (MOE)

1. Under section 1902(gg) of the Social Security Act (the Act), as amended by the Affordable Care Act, as a condition of receiving any Federal payments under the Medicaid program during the MOE period indicated below, the State shall not have in effect any eligibility standards, methodologies, or procedures in its Medicaid program which are more restrictive than such eligibility provisions as in effect in its Medicaid program on March 10, 2010.

   MOE Period.
   - § Begins on: March 10, 2010, and
   - § Ends on: The date the Secretary of the Federal Department of Health and Human Services determines an Exchange established by a State under the provisions of section 1311 of the Affordable Care Act is fully operational.

Is SC in compliance with the conditions of the MOE provision of section 1902(gg) of the Act for continued funding under the Medicaid program?

2. Section 1905(y) and (z) of the Act provides for increased federal medical assistance percentages (FMAP) for expenditures made on or after January 1, 2014 for individuals determined eligible under section 1902(a)(10)(A)(i)(VIII) of the Act. Under section 1905(cc) of the Act, the increased FMAP under sections 1905(y) and (z) would not be available for States that require local political subdivisions to contribute amounts toward the non-Federal share of the State's expenditures at a greater percentage than would have been required on December 31, 2009.

   Prior to January 1, 2014 States may potentially require contributions by local political subdivisions toward the non-Federal share of the States' expenditures at percentages greater than were required on December 31, 2009. However, because of the provisions of section 1905(cc) of the Act, it is important to determine and document/flag any SPAs/State plans which have such greater percentages prior to the January 1, 2014 date in order to anticipate potential violations and/or appropriate corrective actions by the States and the Federal government.

   This SPA would [ ] / would not [ ] violate these provisions, if they remained in effect on or after January 1, 2014.

3. Section 1905(aa) of the Act provides for a "disaster-recovery FMAP" increase effective no earlier than January 1, 2011. Under section 1905(cc) of the Act, the increased FMAP under section 1905(aa) of the Act is not available for States that require local political subdivisions to contribute amounts toward the non-Federal share of the State's expenditures at a greater percentage than would have been required on December 31, 2009.

   This SPA would [ ] / would not [ ] qualify for such increased federal financial participation (FFP) and is not in violation of this requirement.

4. Does SC 11-018 comply with the requirements of section 1902(a)(37) of the Act regarding prompt payment of claims?

We are requesting this additional/clarifying information under provisions of section 1915(f) of the Social Security Act (added by PL 97-35). This has the effect of stopping the 90-day clock for CMS to take action on the material, which would have expired on September 21, 2011. A new 90-day clock will not begin until we receive your response to this request.

In accordance with our guidelines to all State Medicaid Directors dated January 2, 2001, if we have not received the State's response to our request for additional information within 90 days from the date of this letter, we will initiate disapproval action on the amendment.

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If you have any questions or need any further assistance, please contact Yvette Moore at (404) 562-7327.

Sincerely,

Jackie Glaze

Jackie Glaze
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosure

Brenda James

Log # 123

From: Janet Bell
Sent: Friday, October 12, 2012 3:45 PM
To: Brenda James
Cc: Ruth Johnson; Jeff Saxon; Sheila Chavis; Roy Hess
Subject: FW: RE: SC SPA 11-018 Request for Additional Information
Attachments: Attachment 3.1-A Limit Supp 5 5a (final).pdf; Attachment 4.19-B Final.pdf; Funding Question #2.pdf; Revised HCFA FORM 179.pdf; SC 11-018 Jackie L. Glaze Letter.pdf; 3 1-A Limitation Supplement pages 5 5a 8 29 12 final JS MR 9 23 12.docx; 3 1-A Limitation Supplement pages 5 5a 8 29 12 Final Tck Change Doc w MR JS Edits 10 5 12.docx; Attachment 4.19b pages Final no trking to RJ 10 9 12.docx; Attachment 4.19b pages Final track change doc with DS and JS edits 10 5 12.docx

Brenda,
This will close log letter 000123 from 2012. (Ruth inherited this log from Roy.) Thanks!
Janet

From: Sheila Chavis
Sent: Friday, October 12, 2012 10:39 AM
To: SPA_Waivers_Atlanta_R04@cms.hhs.gov
Cc: Byron Roberts; Cheryl.Wigfall@cms.hhs.gov; Davida R. (CMS/CMCHO) Kimble (Davida.Kimble@cms.hhs.gov); Deirdra Singleton; Jackie.Glaze@cms.hhs.gov; Jan Polatty; Jeff Saxon; John Supra; Joyce.Wilkerson@cms.hhs.gov; Marie Brown; Mary E. (CMS/CMCS) Cieslicki (Mary.Cieslicki@cms.hhs.gov); Mary V. (CMS/CMCHO) Holly (Mary.Holly@cms.hhs.gov); Melanie Giese; Michelle.White@cms.hhs.gov; Rick Hepfer; Rosario.Gilbert@cms.hhs.gov; Roy Hess; SAM WALDREP; Shantrina D. (CMS/CMCHO) Roberts (Shantrina.Roberts@cms.hhs.gov); Sheila Chavis; Mariann Gable; Valeria Williams; Yvette (CMS/CMCHO) Moore (yvette.moore@cms.hhs.gov); Ruth Johnson; Janet Bell; Maureen Ryan
Subject: RE: SC SPA 11-018 Request for Additional Information

WE ARE RE-SENDING THE FILE REGARDING SC 11-018 DUE TO ONE OF THE ATTACHMENTS WAS NOT ADDED. SORRY FOR THE INCONVENIENCE.

Please find attached the Request for Additional Information on SPA SC 11-018 for your review and approval. We have also included a revised HCFA Form 179 to add Attachment 4.19-B pages 3a, 3a.1, 3a.2, 3a.3, 3a.4, 3a.5, 3a.6 & 3a.7 and Attachment 3.1-A Limitation Supplement pages 5 & 5a. We are giving you the authorization to make the appropriate pen and ink change on the HCFA Form 179 in block 8 and block 9. If additional information is needed please let me know. Thanks!

Sheila Chavis
SC Department of Health and Human Services
Office of Legislative Affairs and Communications
1801 Main Street
PO Box 8206
Columbia, SC 29202-8206
chaviss@scdhhs.gov

Log #23

South Carolina Department of Health & Human Services

Anthony E. Keck • Director
Nikki R. Haley • Governor

October 10, 2012

Ms. Jackie L. Glaze, Associate Regional Administrator
Division of Medicaid and Children's Health Operations
Centers for Medicare and Medicaid Services
61 Forsyth Street, suite 4T20
Atlanta, Georgia 30303-8909
ATTN: Maria Drake

Re: Request for Additional Information (RAI) for South Carolina Title XIX State Plan Amendment SC 11-018

Dear Ms. Glaze:

This is in response to your RAI dated September 8, 2011 and your amended RAI dated October 19, 2011. Please find below the South Carolina Department of Health and Human Services' (SCDHHS) responses to your requests.

1. Your cover letter states you provided the standard funding questions (SFQ) responses with the submission of SC 11-001. Each SPA submission is a stand alone submission and all pertinent documents must be provided. During the review SC 11-001, SC requested that all concerns outside the initial submission be addressed through the companion letter process therefore the SFQ's were not provided. As part of our review of SC 11-018, we want to ascertain that the funding associated with clinical and dental reimbursement has been appropriately evaluated and is in accordance with federal guidelines.

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Office of the Director
P.O. Box 8206• Columbia, South Carolina 29202-8206
(803) 898-2504 • Fax (803) 255-8235

SCDHHS Response:
All dental and clinic providers receiving reimbursement under this state plan amendment will retain one hundred percent of the Medicaid payments that they receive from the SCDHHS for services provided via SC 11-018.

2. Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state share of each type of Medicaid payment (normal per diem, supplemental, enhanced, other) is funded. Please describe whether the state share is from appropriations from the legislature, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either an IGT or CPE. In this case, please identify the agency to which the funds are appropriated. Please provide an estimate of total expenditure and State share amounts for each type of Medicaid payment. If any of the non-federal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the state agency receives the transferred amounts from the local government entity transferring the funds.

   If CPEs are used, please describe the methodology used by the state to verify that the total expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b). For any payment funded by CPEs or IGTs, please provide the following:

   (i) a complete list of the names of entities transferring or certifying funds;

   (ii) the operational nature of the entity (state, county, city, other);

   (iii) the total amounts transferred or certified by each entity;

   (iv) clarify whether the certifying or transferring entity has general taxing authority: and,

   (v) whether the certifying or transferring entity received appropriations (identify level of appropriations).

SCDHHS Response:
Please see the enclosed documentation for responses to the above questions.

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The South Carolina Department of Mental Health (SCDMH), the Medical University of South Carolina (MUSC), and the University of South Carolina (USC) use certified public expenditures (CPE) as the source of state matching funds. SCDMH, MUSC, and USC file annual cost reports to the SCDHHS which are used as documentation of CPE and rate analysis. The following CPE contract language has been developed and is incorporated into each of the above entity's contract:

"SCDMH/MUSC/USC agrees to incur expenditures from state appropriated funds and/or funds derived from tax revenue in an amount at least equal to the non-federal share of the allowable, reasonable and necessary cost for the provision of services to be provided to Medicaid recipients under this contract prior to submitting claims for payment under this contract. Documentation of the non-federal expenditures necessary to support the claims for reimbursement must be maintained by SCDDSN/SCDMH and are subject to audit by SCDHHS. SCDHHS may withhold and/or recoup reimbursements if Certified Public Expenditures are not adequately documented. As required by 45 CFR Part 201.5, all funds expended for the non-federal share of this contract must be in compliance with 42 CFR Part 433 Subpart B. Such non-federal funds must be actually expended for the provision of services to be provided under this contract."

In regards to non-state owned governmental Outpatient Pediatric Aids Clinics (OPACs) receiving claims related payments, the OPACs will be required to transfer the state matching funds via IGTs in advance, prior to receiving the claims related payments.

3. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.

SCDHHS Response:
Supplemental payments (i.e. retrospective cost settlements) are made to SCDMH Community Mental Health Clinics and the MUSC Mental Health Clinic under this specific plan amendment. There are no enhanced payments made. Annual supplemental payments are estimated to be approximately $25 million (total dollars).

4. For clinic or outpatient hospital services please provide a detailed description of the methodology used by the state to estimate the upper payment limit (UPL) for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated). Please provide a current (i.e. applicable to the current rate year) UPL demonstration.

   SCDHHS Response:
   A copy of our clinic demonstration with a description of the UPL methodology will be sent under separate cover.

5. Does any governmental provider receive payments that in the aggregate (normal per diem, supplemental, enhanced, other) exceed their reasonable costs of providing services? If payments exceed the cost of services, do you recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?

   SCDHHS Response:
   The SCDMH Community Mental Health Clinics and the MUSC Mental Health Clinic are paid retrospectively their total allowable costs. In the event that the SCDMH Community Mental Health Clinics and the MUSC Mental Health Clinic are overpaid as a result of our review of the provider's cost report, the SCDHHS will recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report. Additionally, in the event that the MUSC and USC Outpatient Pediatric Aides Clinics Medicaid payments exceeds its allowable Medicaid costs, the SCDHHS will recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report.

2. *4.19B, Page 3a, Section 9, Clinical Services*- The weblink included in the SPA amendment is generic and does not directly link the viewer to the fee schedule associated with clinical services. Please revise the weblink such that when it is opened the fee schedules are visible.

   SCDHHS Response:
   We are enclosing pages 3a, 3a.1, 3a.2, 3a.3, 3a.4, 3a.5, 3a.6 and 3a.7 of Attachment 4.19-B which addresses the different payment methodologies for the clinic types identified.

3. *4.19B, Page 3a, Section 10, Dental Services*- The weblinks included in the SPA amendment are generic and do not directly link the viewer to the fee schedules associated with dental services. Please revise the weblinks such that when they are opened, the fee schedules are visible.

   SCDHHS Response:
   We have inserted the correct weblink to the Dental fee schedule and changed the language in the plan accordingly.

Maintenance of Effort (MOE) Questions

1. Under section 1902(gg) of the Social Security Act (the Act), as amended by the Affordable Care Act, as a condition of receiving any Federal payments under the Medicaid program during the MOE period indicated below, the State shall not have in effect any eligibility standards, methodologies, or procedures in its Medicaid program which are more restrictive than such eligibility provisions as in effect in its Medicaid program on March 10, 2010.

   MOE Period.

   § Begins on: March 10, 2010, and
   § Ends on: The date the Secretary of the Federal Department of Health and Human Services determines an Exchange established by a State under the provisions of section 1311 of the Affordable Care Act is fully operational.

   Is SC in compliance with the conditions of the MOE provision of section 1902(gg) of the Act for continued funding under the Medicaid program?

   SCDHHS Response:
   Yes

2. Section 1905(y) and (z) of the Act provides for increased federal medical assistance percentages (FMAP) for expenditures made on or after January 1, 2014 for individuals determined eligible under section 1902(a)(10)(A)(i)(VIII) of the Act. Under section 1905(cc) of the Act, the increased FMAP under sections 1905(y) and (z) would not be available for States that require local political subdivisions to contribute amounts toward the non-Federal share of the State's expenditures at a greater percentage than would have been required on December 31, 2009.

   Prior to January 1, 2014 States may potentially require contributions by local political subdivisions toward the non-Federal share of the States' expenditures at percentages greater than were required on December 31, 2009. However, because of the provisions of section 1905(cc) of the Act, it is important to determine and document/flag any SPAs/State plans which have such greater percentages prior to the January 1, 2014 date in order to anticipate potential violations and/or appropriate corrective actions by the States and the Federal government.

This SPA would [ ] / would not [X] violate these provisions, if they remained in effect on or after January 1, 2014.

3. Section 1905(aa) of the Act provides for a "disaster-recovery FMAP" increase effective no earlier than January 1, 2011. Under section 1905(cc) of the Act, the increased FMAP under section 1905(aa) of the Act is not available for States that require local political subdivisions to contribute amounts toward the non-Federal share of the State's expenditures at a greater percentage than would have been required on December 31, 2009.

   This SPA would [ ] / would not [X] qualify for such increased federal financial participation (FFP) and is not in violation of this requirement.

4. Does SC 12-012 comply with the requirements of section 1902(a)(37) of the Act regarding prompt payment of claims?

   SCDHHS Response:
   Yes

If you have any questions concerning the revisions to the subject plan amendment, please contact Jeff Saxon, Bureau of Reimbursement Methodology and Policy, at (803) 898-1023 or Sheila Chavis, Office of Legislative Affairs and Communications, at (803) 898-2707. We apologize for the delay in responding to your request.

Sincerely,

Anthony E. Keck
Director

AK/s

Enclosures

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When home health services are provided, the service a patient receives is counted in visits. A visit is a face-to-face encounter between a patient and any qualified home health professional whose services are reimbursed under the Medicaid program and ordered by a physician as part of a written plan of care every sixty (60) days.

Home health agency visits are limited to a total of fifty (50) per recipient per state fiscal year for all mandatory and optional home health services for beneficiaries over the age of 21 and does not apply to children. For situations where it is medically necessary for a beneficiary to exceed the fifty (50) visit limitation, a request for additional visits accompanied by supporting medical documentation which would document the necessity for the additional home health visits will be reviewed by the South Carolina Department of Health and Human Services medical reviewer for approval. In accordance with EPSDT requirements any therapy service that is provided beyond the limits would require prior approval if determined medically necessary.

9. CLINIC SERVICES:

Clinic services are limited to outpatient ambulatory centers that provide medical services which include all primary, preventive, therapeutic, palliative items, and rehabilitative services. All services must be provided by a facility that is not part of a hospital, but is organized and operated to provide medical care to outpatients. All services must be furnished by or under the direction of a physician. Covered Clinic services include:

AMBULATORY SURGICAL CENTERS: Medical coverage is limited to medically necessary services provided by certified and licensed ambulatory surgical centers that meet the conditions for Medicare coverage as established in 42 CFR, Part 416, Subpart B, (Conditions for coverage), and as evidenced by an agreement with HCFA.

The surgical procedures covered are limited to those described under 42 CFR Part 416, Subpart B, (Scope of Benefits), and those procedures published in the South Carolina Medicaid Physician and Clinical Services Manual, with appropriate revisions and updates.

END STAGE RENAL DISEASE CLINICS: Medicaid coverage includes all medically necessary treatments and services for in-center or home dialysis as described in the South Carolina Medicaid Physician and Clinical Services Manual.

Medicaid coverage is limited to services provided by licensed ESRD clinics meeting the Medicare requirements outlined in 42 CFR Part 250 and participating in Medicare as evidenced by a Medicare agreement.

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 and defined in the current addition of the Diagnostic Statistical Manual (DSM).

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.

10. DENTAL SERVICES

Dental services for recipients under 21 include any medically necessary dental services.

11.a PHYSICAL THERAPY

Physical Therapy Services:

Other physical therapy services not related to EPSDT must be provided in accordance with SCDHHS hospital, physician, and home health manuals.

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. Durable medical equipment purchased through a home health agency will be reimbursed in accordance with Section 12 c of this plan 4.19-B. 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.

8. Durable Medical Equipment is equipment that can withstand repeated use and is primarily and customarily used to serve a medical purpose. Generally it is not useful to a person in the absence of illness or injury and is appropriate for use in the Reimbursement is based on the lesser of billed charges, State Agency determined allowable fees, or the Medicare prevailing charge (50% percentile).

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

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 below have been established to provide adequate payments to the providers of these services.

   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 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:

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.

Multiple surgeries (same day): Multiple surgeries performed during the same operative session will be reimbursed for the procedure that has the highest established rate (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.

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.

Hospital based certified ESRD clinics are reimbursed using the methodology described in this section. Hospital outpatient dialysis services are billed on the UB claim form and reimbursed under the outpatient fee schedule described in section 2a of 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.

Medicaid will reimburse as the primary sponsor of ESRD services during the 90 day waiting period required by Medicare for eligibility determinations and when the individual has been denied Medicare coverage.

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

Medicaid reimbursement 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 - 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 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:

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 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,

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

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 HIM-15, Chapter 2300, Section 2313.2 (E) 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 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 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 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 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. 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 HIM-15, Chapter 2300, Section 2313.2 (E) 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 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

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.

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.

South Carolina Department of Health and Human Services
Projected Total Annual Expenditures and State Share Amounts
For Dental and Clinic Services Described in SC 11-018
Based Upon SFY 2011 Expenditures and 3% Reduction Annualized
And Implementation of State Plan Amendment SC 11-018
Enclosure Applicable to CMS Funding Question #2, Items (i) Through (v)

Entity	CPE	IGT	Operational Nature	Total Amounts Transferred/Certified (2)	General Taxing Authority (1)	Does Entity Receive State Appropriations?	SFY 2009 State Appropriations Received (3)
South Carolina Department of Mental Health	x		State	$ 30,873,837	No	Yes	$ 147,389,163
Medical University of South Carolina	x		State	$ 1,862,500	No	Yes	$ 67,624,714
University of South Carolina	x		State	$ 30,322	No	Yes	$ 128,424,218
Greenville Hospital System		x	County	$ 5,682	No	No	$ -

Notes: (1) - While the state agency does not have taxing authority, the state does.
(2) - Total amounts certified based upon estimated SFY 2011 expenditures as reflected on summary report.
(3) - Source Document Used - Office of State Budget - FY 2010-2011 Appropriations Act Final Summary Control Document

South Carolina Department of Health and Human Services
Actual/Projected Total Annual Expenditures and State Share Amounts for SFY 2011
For Dental and Clinic Services
Based Upon SFY 2011 Expenditures and 3% Reduction Annualized
And Implementation of State Plan Amendment SC 11-018
Enclosure Applicable to CMS Funding Question #2

Type of Service	Projected Total Payments	Projected State Share
Dental	$ 103,455,885	$ 29,650,457
Dental SCHIP	$ 1,234,946	$ 258,351
Ambulatory Surgical Centers	$ 4,308,801	$ 1,234,902
End Stage Renal Disease Clinics	$ 11,638,871	$ 3,335,700
Community Mental Health Clinics	$ 114,064,452	$ 32,690,872
Outpatient Pediatric Aids Clinics	$ 284,260	$ 81,469
Infusion Centers	$ 3,419,361	$ 979,989
Projected Total For SFY 2011	$ 238,406,576	$ 68,231,740

(1) State Share:	28.66%
(2) State Share SCHIP	20.92%