DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Singleton / Travis	6-713

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 000383	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR _____	[ ] Prepare reply for appropriate signature DATE DUE _____ [ ] 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
Atlanta Regional Office
61 Forsyth Street, Suite 4T20
Atlanta, Georgia 30303

CENTERS FOR MEDICARE & MEDICAID SERVICES

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

May 23, 2013

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

Re: Title XIX State Plan Amendment, Transmittal 13-003

Dear Mr. Keck:

We accept your request, dated May 22, 2013, to withdraw South Carolina 13-003. We are returning the form HCFA-179 and proposed plan pages.

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

Sincerely,

Jackie Glaze

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

Enclosures

→ Lori Singleton / Chavis

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 13-003

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
January 1, 2013

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 447.405, 447.410, 447.415

7. FEDERAL BUDGET IMPACT:
a. FFY 2013 $ 30,571,600
b. FFY 2014 $ 54,650,400

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Supplement 3 to Attachment 4.19-B, page 5, 6, 7 & 8

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

10. SUBJECT OF AMENDMENT:
Increased Primary Care Services Payment Methodology for Medicaid Managed Care Plans Effective January 1, 2013 as required by the Affordable Care Act.

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:
March 27, 2013

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:

18. DATE APPROVED:

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

22. TITLE:

23. REMARKS:

Reimbursement Managed Care

Increased Primary Care Services Payment

42 CFR 438.6, 438.804, 441.605, 441.610, 441.615447.400, 447.405, 447.410, and 447.415

Attachment 4.19-B: Managed Care 42 CFR 438.6, and 438.804

Under this methodology, DHHS will pay enhanced rates to eligible managed care physicians utilizing the encounter data and paying the rate differential between the current fee-for-service rate with a 2% adjustment and the Medicare targeted amount in 2013 or 2014 for primary care services affected by this payment methodology. The supplemental payments to providers who serve the managed care population will be calculated quarterly using each plan's encounter data rather than the fee-for-service claims data. Calculations will utilize the state's CPT-4 code list and the state's eligible provider list.

During the past several years, DHHS and the managed care plans have made a significant investment in the development of a quality encounter data system. Further, the current contract between DHHS and the health plans requires that the encounter data to be at least 97% complete. With regard to the E&M codes, the level of completeness of the encounter data was very high for all of the health plans and reconciled closely with reports prepared by the health plans.

Calculations developed for each health plan will be compiled into detailed reports listing claims eligible for supplemental payments for each eligible provider. The reports will be reviewed by DHHS and the appropriate health plan. This will allow each plan to reconcile to the calculations developed based on the encounter data and suggest corrections or additions, as appropriate. After each health plan has completed the reconciliation process with the supplemental payment contractor, DHHS will perform a final review. Payments to providers will be made by the plan based on the final approved report. DHHS will provide the required funding to the plan on a non-risk basis.

The final approved reports used by the plans to make supplemental payments to providers will also be used for quarterly CMS-64 reporting. The reports will also develop amounts eligible for 100% FFP. For codes where reimbursement has decreased since July 1, 2009, only a portion of the enhanced reimbursement may be eligible for 100% FFP.

This methodology ensures that eligible physicians serving managed care enrollees receive direct benefit from the payment increase for primary care services. The supplemental benefits they receive will mirror those they would have received had they been serving the fee-for-service Medicaid enrollees. As with the FFS process, supplemental payments to each physician will be supported by a set of encounter claims and calculations to allow the process to be completely transparent to the provider, the contracted health plan, DHHS and CMS.

2009 Baseline Rate and Rate Differential

The final rule requires States to receive CMS approval for methodologies for determining the *2009 baseline rate* and the *rate differential eligible for 100% federal match.*

It is our understanding that by *2009 baseline rates*, the final rule envisioned development of CY 2013 capitation rates in which eligible primary care services to eligible providers are assumed to be paid using the same reimbursement used to develop the CY 2009 capitation rates. Similarly, *rate differential eligible for 100% federal match* would refer to the difference between rates developed based on reimbursement of eligible primary care services to eligible providers at the Medicare fee schedule and the *2009 baseline rates*.

South Carolina's managed care capitation rates are currently developed using encounter data. However, in July 2009, the capitation rates were developed using Medicaid fee-for-service population experience for the managed care eligible population. The cost per unit in the July 1, 2009 capitation rate was based on Medicaid fee-for-service with a 2% increase to reflect anticipated contract rate adjustments. Since we are proposing a non-risk based methodology that does not require development of a rate, we believe the requirement to develop the *2009 baseline rate* and *rate differential eligible for 100% federal match* may be satisfied by the code list developed by DHHS for making supplemental payments to primary care physicians with a 2% adjustment for the underlying contract adjustment.

Other Requirements in the Final Rule

This section addresses required elements listed on page 62 of the final rule.

Provide payment at the minimum Medicare primary payment levels

Supplemental payments will be made to each physician based on all eligible encounters to ensure that payment for each encounter is made at the minimum Medicare primary payment level.

Require that eligible physicians receive direct benefit of the payment increase for each of the primary care services specified in this rule

Supplemental payments based on the encounters would be made directly from the plan to physicians.

Require that all information needed to adequately document expenditures eligible for 100 percent FFP is reported by MCOs to the states, which in turn will report this information to CMS

The reporting process will develop claim level records for each health plan by eligible provider. These records will be developed from the encounter data and reviewed by the plans. Each claim record will include the service provided (by procedure code), date of service, amount originally paid, the supplemental payment amount, and the portion of the supplemental payment amount eligible for 100% FFP. Because the record would be at a service level detail, the calculated supplemental payment amount and the amount eligible for 100% FFP will be readily available for review and audit, using the code list developed by DHHS for the FFS population.

Specify that states must receive from MCOs data on primary care services which qualify for payment under this rule.

Under the proposed methodology, the plans will provide DHHS with complete claims level data on primary care services which qualify for payment under the rule, both through the encounter data system and as adjusted through subsequent plan review.

Concerns with Risk-Based Payment Methodology

Developing an estimate of the cost of the primary care physician reimbursement related to health plan enrollees requires the actuary to estimate two values for each rate group: 1) Projected utilization of eligible primary care services and 2) Percentage of primary care services provided by eligible providers. The first estimate may be developed based on historical utilization; although, utilization often changes over time. However the second estimate, the percentage of primary care services provided by eligible providers may be difficult to accurately estimate. It is unclear how many physicians are eligible, and also how many of those will self-attest. The number of physicians who self-attest may be strongly impacted by State outreach efforts and also by communications from the hospitals and practices with which they are affiliated.