


**DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR**

ACTION REFERRAL

TO <i>Mells</i>	DATE <i>3-9-09</i>
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DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER <i>100493</i>	<input type="checkbox"/> Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR 	<input type="checkbox"/> Prepare reply for appropriate signature DATE DUE _____
	<input type="checkbox"/> FOIA DATE DUE _____
	<input checked="" type="checkbox"/> 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 4120
Atlanta, Georgia 30303-8909



RECEIVED

MAR 09 2009

February 10, 2009

Department of Health & Human Services
OFFICE OF THE DIRECTOR

Ms. Emma Forkner, Director
South Carolina Department of Health and Human Services
Post Office Box 8206
Columbia, South Carolina 29202-8206

Re: South Carolina Title XIX State Plan Amendment, Transmittal #08-32

Dear Ms. Forkner:

We accept your request, dated February 9, 2009, to withdraw State Plan Amendment 08-032. We are returning the Form HCFA-179 and the proposed amendment pages.

If you have any questions regarding this amendment, please contact Elaine Elmore at (404) 562-7408 or Tandra Hodges at (404) 562-7409.

Sincerely,

Mary Kaye Justis, RN, MBA
Acting Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosures

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL**

1. TRANSMITTAL NUMBER:
SC 08-032

2. STATE
South Carolina

FOR: HEALTH CARE FINANCING ADMINISTRATION

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

TO: REGIONAL ADMINISTRATOR

4. PROPOSED EFFECTIVE DATE
February 1, 2009

HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

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:

7. FEDERAL BUDGET IMPACT:

a. FFY 2009 (\$3,396,654)
b. FFY 2010 (\$5,094,981)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.18-A, Page 1

Attachment 4.19-B, Pages 1c, 1e, 1g, 2a.2, 3, 3a, 3b, 4a, and 5

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION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

Attachment 4.18-A, Page 1
Attachment 4.19-B, Pages 1c, 1e, 1g, 2a.2, 3, 3a, 3b, 4a, and 5

10. SUBJECT OF AMENDMENT:

Update the co-pays for services.

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:

Ms. Forkner was designated by the Governor
to review and approve all State Plans

12. SIGNATURE OF STATE AGENCY OFFICIAL:

16. RETURN TO:

Emma Forkner

13. TYPED NAME:

Emma Forkner

14. TITLE:

Director

15. DATE SUBMITTED:

December 18, 2008

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:

- b. an updated outpatient cost-to-charge ratio;
- c. an analysis reflecting the financial impact of the reimbursement change effective October 1, 2007.

The provider request will be reviewed by SCDHHS staff to determine if an interim settlement adjustment is justified based upon the best available information at the time.

This methodology will expire September 30, 2009.

Upper Payment Limits:

Outpatient hospital reimbursement shall be made in accordance with the upper payment limit requirements defined in 42 CFR 447.321.

Cost Report Requirements:

Cost report requirements under the prospective payment system and retrospective reimbursement system will conform to Medicare cost reporting principles and use as their basis the Medicare Cost Report Form - CMS-2552. In addition, providers must comply with Medicaid specific cost report requirements as published by the DHHS.

Audit Requirements:

All cost report financial and statistical information, the medical information contained on claims and information contained on supplemental worksheets such as the DSH survey, are subject to audit by the DHHS or its designee. The audited information will be used for future rate calculations, retrospective cost settlements, disproportionate share program requirements, utilization review contractor requirements and other analyses.

Co-payment Requirements:

Effective for dates of service February 1, 2009, there is a standard co-payment (42 CFR 447.55) of \$3.40 per outpatient non-emergency service furnished in a hospital emergency room when co-payment is applicable (42 CFR 447.53). Emergency services are not subject to co-payment. The outpatient cost settlement payment calculation will include uncollected Medicaid co-payment amounts in accordance with 42 CFR 447.57.

B.

Objectives

Implementation of the reimbursement methodology provided herein has the following objectives:

- To encourage outpatient resources be used when they are appropriate substitute for inpatient hospital services.
- To discourage the inappropriateness of outpatient hospital resources as a substitute for physician office and clinic services.
- To ensure the continued existence and stability of the core providers who serve the Medicaid population.

IV. Payments to Out-of-State Providers:

Payments to out-of-state providers shall be made based on the lesser of the fixed fee specified for the service or the charge for the service in the case of surgery, nonsurgery or treatment, therapy and testing services.

2b.

Rural Health Clinics:

Effective January 1, 2001, in accordance with the requirements of BIPA 2000, an alternative payment methodology will be used for reimbursement of Rural Health Clinics (RHCs). The alternative payment methodology is described below. It has been determined by a comparison of rates using the prospective payment methodology (PPS) and the alternative payment methodology that the alternative methodology as described will provide reimbursement to RHCs which is at least equal to the amount that would be received using the PPS methodology. The FY 01 PPS baseline rates were determined by weighing the RHC specific rates for FYs 1999 and 2000 using Medicare cost principles, by the number of Medicaid encounters provided each year.

The alternative payment methodology is a cost based retrospective reimbursement system. Reimbursement for medically necessary services will be made at 100% of the all-inclusive rate per encounter as established by the Medicare Intermediary. Actual cost information shall be obtained from the Medicare Intermediary at the end of the RHC's fiscal reporting period to enable SCDHHS to determine the reimbursement due for the period. Provider-based RHCs with less than fifty (50) beds will receive reimbursement at 100% of Medicare reasonable costs not subject to the RHC rate cap. For provider-based RHCs, actual cost and utilization information based on the RHC's fiscal year shall be obtained from the HCFA-2552-96 actual cost report.

At year-end settlement under the alternative payment methodology, comparisons will be made to assure that the final rate paid based on the RHC's fiscal year will provide reimbursement at least equal to the amount available under the PPS methodology.

Effective February 1, 2009, there is a standard co-payment amount of \$3.40 per encounter provided (42 CFR 447.55) when co-payment is applicable (42 CFR 447.53).

Circumstances requiring special consideration/disposition are discussed below:

1. For RHCs not agreeing to the cost based alternative payment methodology, reimbursement for a provider's fiscal year will be based on the provider's PPS FY 01 baseline rate which will be updated annually for: 1) the Medicare Economic Index (MEI) and 2) any increases or decreases in the scope of services furnished by that provider during that fiscal year.

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SUPERSEDES: MA 03-013

For those facilities that are not PHS grantees but are designated as "look alikes", the same cost principles and constraints shall apply as mentioned above for FQHCs.

At year-end settlement, under the alternative payment methodology, comparisons will be made to assure that the final rate paid for a FQHC's fiscal year will provide reimbursement at least equal to the amount available under the PPS methodology.

Effective February 1, 2009, there is a standard co-payment amount of \$3.40 per encounter provided (42 CFR 447.55) when co-payment is applicable (42 CFR 447.53).

Circumstances requiring special consideration/disposition are outlined below:

1. For FQHCs not agreeing to the cost based alternative payment methodology, reimbursement for a provider's fiscal year will be based on the provider's PPS FY 01 baseline rate which will be updated annually for: 1) the Medicare Economic Index (MEI) and 2) any increases or decreases in the scope of services furnished by that provider during that fiscal year.
2. Under the alternative payment methodology, new FQHCs will initially be reimbursed at 100% of the all-inclusive encounter rate as determined from a review of a budget submitted by the FQHC. Reimbursement will be reconciled to actual cost on an annual basis based on the FQHC's fiscal year. In the event that a new FQHC wishes to elect the PPS rate, the PPS rate established shall be equal to 100% of the reasonable costs used in calculating the rates of like FQHCs in the same or an adjacent area with a similar caseload.
3. For those FQHCs participating as a member of a Medicaid managed care entity (MCE), and receiving either cost based or PPS reimbursement, quarterly reconciliation will be completed. Where necessary, supplemental payments will be made to ensure that the FQHC does not receive less reimbursement than would be received under the cost based or PPS reimbursement methodologies. An annual reconciliation of quarterly supplemental payments will be included in the FQHC's fiscal year cost settlement and rate determination.

2e. Indian Health Service (IHS) Facilities:

Effective July 1, 1999, DHHS will reimburse IHS facilities (638 facilities) at the rate as determined by the Indian Health Service. For Calendar Year 1999, the rate is published in the Federal Register/Vol.64, No. 16/Tuesday, January 26, 1999/Notices, page 3955. Subsequent year rates shall be announced in the Federal Register. The rate shall be an all-inclusive encounter rate per visit for the provision of medically necessary out-patient services provided to both Native and non-Native Americans.

Coinurance and Deductibles will be paid by the Medicaid Program (Title XIX) program where the individual has joint eligibility for Medicare and Medicaid.

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SUPERSEDES: MA 03-013

These CPT codes were chosen and averaged as the activities performed as a part of Orientation and Mobility Services most closely identify with various components defined in the three CPT codes listed above. The Medicaid rate has been reduced from 100% of the Medicare average rate to acknowledge the differences in the credentials required for providers of Orientation and Mobility Services from those of the Medicare covered CPT codes.

Nursing Services for Children Under 21:

Initial reimbursement to providers of nursing services for children under the age of 21 is made on the basis of an established fee schedule not to exceed the prevailing charges in the locality for comparable services under comparable circumstances. Reimbursement will be provided on a unit of a quarter of an hour basis for skilled nursing services and a per encounter basis for medication administration and other similar procedures. The current reimbursement rates are based on rates or fees reimbursed for similar services.

State and local government providers must submit annual actual cost and service delivery data. The State shall utilize Medicare reasonable cost principles as well as OMB Circular A-87 and other OMB circulars as may be appropriate during its review of actual allowable costs. Future reimbursement rates to state and local government providers shall be the lesser of actual allowable documented cost or the established fee.

4.c Family Planning Services and Supplies:

Family Planning Services are reimbursed at an established fee schedule based on cost or by the methodologies set forth in other sections of the Plan.

5. Physician Services:

Effective February 1, 2009, there is a standard co-payment of \$3.40 per office visit provided (42 CFR 447.55) when co-payment is applicable (42 CFR 447.53). Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of physician services (including pediatric sub-specialists) and any annual/periodic adjustments to the fee schedule are published in Medicaid Bulletins. All physician services will be reimbursed based on a Fee Schedule that in the aggregate will not exceed 100 percent of Medicare. For those procedures that are non-covered by Medicare, reimbursement is based on data collected within the Medicaid Management Information System or by a review conducted by medical personnel to establish the relative value. The Anesthesiologist providing the medical directed supervision of a Certified Registered Nurse Anesthetist (CRNA) will be reimbursed at 60 percent of the reimbursement rate.

Effective July 1, 2005, pediatric sub-specialist providers will receive an enhanced Medicaid rate for evaluation & management, medical & surgical procedure codes. These enhanced rates are established at 120 percent of the Medicare fee schedule for certain evaluation and management codes as determined by the state agency. All other CPT codes will be reimbursed at 100 percent of the Medicare fee schedule. Pediatric sub-specialist providers are those medical personnel that meet the following criteria: a) have at least 85% of their patients who are children 18 years or younger; b) practice in the field of Adolescent Medicine, Cardiology,

Reimbursement for laboratory (pathology) services performed by individual practitioners is calculated as specified in 5.

End State 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.

6.a Podiatrists' Services:

Effective February 1, 2009, there is a standard co-payment of \$3.40 per office visit provided (42 CFR 447.55) when co-payment is applicable (42 CFR 447.53). Reimbursement is calculated in the same manner as for physicians' services. Refer to 5.

6.b Optometrists' Services (Vision Care Services):

Effective February 1, 2009, there is a standard co-payment of \$3.40 per office visit provided (42 CFR 447.55) when co-payment is applicable (42 CFR 447.53). Payment will be according to an established fee schedule for all services not provided through the sole source contract. Effective February 1, 1982.

6.c Chiropractor's Services:

Effective February 1, 2009, there is a standard co-payment of \$2.30 per office visit provided (42 CFR 447.55) when co-payment is applicable (42 CFR 447.53). Reimbursement is calculated in the same manner as for physicians' services. Refer to 5.

6.d

Certified Registered Nurse Anesthetist(CRNA): CRNAs under the medical direction of a surgeon will be reimbursed at 90 percent of the Anesthesiologist reimbursement rate. CRNAs under the medical direction of an Anesthesiologist will receive 50 percent of the reimbursement rate. Refer to 5 Physician Services.

Nurse Practitioner: Effective February 1, 2009, there is a standard co-payment of \$3.40 per office visit when co-payment is applicable. Reimbursement is calculated at 80 percent of the rate for Physician Services. Refer to 5.

Psychologists: Psychological services are reimbursed at an established statewide fee schedule as based on the Methodology outlined in the Physician Section 5, Attachment 4.19-B, Page 2a. All requirements identified under CFR 447.200ff and 447.300ff shall be met.

Licensed Midwives' Services: Effective February 1, 2009, there is a standard co-payment of \$3.40 per office visit when co-payment is applicable. Reimbursement is calculated at 65% of the rate for physician services. Refer to 5a and 5b.

Medical Social Services: Governmental and non-governmental providers of Medical Social Services are reimbursed using the same payment methodology as those services described under the Medicaid Home Health benefit. See section Attachment 4.19-B, Section 7. There is a standard co-payment of \$3.40 per home visit when applicable.

7. Home Health Services:

Nursing Services, Home Health Aide Services, Physical Therapy, Occupational Therapy, Speech Pathology, and Audiology are provided and reimbursed based on the lesser of allowable Medicare costs, charges, or the Medicare cost limits. At the end of each Home Health Agency's fiscal year end, an actual cost report must be submitted which is used for the purpose of completing a cost settlement based on the lesser of allowable Medicare costs, charges, or the Medicare cost limits.

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. Effective February 1, 2009, there is a standard co-payment amount of \$3.40 per visit provided (42 CFR 447.55) when co-payment is applicable (42 CFR 447.53). 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.

B. 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 (50th percentile).

Effective February 1, 2009, there is a standard co-payment (42 CFR 447.55) of \$.60 - 3.40 for Durable Medical Equipment services furnished when co-payment is applicable (42 CFR 447.53). Pregnant women, individuals participating in family planning services, infants and children up to age 19 will not be subject to co-pay.

Clinical Services:

Payment will be made according to an established fee schedule and will not exceed the allowable payment established for those services by Medicare (Title XVIII). There is a standard co-payment of \$3.40 per claim for clinic services (42 CFR 447.55) provided by County Health Departments when co-payments is applicable (42 CFR 447.53). Pregnant women, individuals participating in family planning services, infants and children up to age 19 will not be subject to co-pay.

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.

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SUPERSEDES: MA 03-013

Effective February 1, 2009, there is a standard co-payment (42 CFR 447.55) of \$3.40 for dental services furnished when co-payment is applicable (42 CFR 447.53). Pregnant women, individuals participating in family planning services, infants and children up to age 19 will not be subject to co-pay.

11.a. Physical Therapy/Occupational Therapy:

- 11.b. Payment will be according to an established fee schedule as based on the methodology outlined in the Physician Section 5, Attachment 419-B, Page 2a. All requirements identified under 42 CFR 447.200ff and 447.300ff shall be met.

11.c. Speech/Language and Audiological Services:

Payment will be according to an established fee schedule.

12.a. Prescribed Drugs:

Medicaid pays for FDA approved prescribed drugs with stated exceptions described in Attachment 3.1-A, Item 12-A, Limitation Supplement.

1. Basis for Payment:

A. MULTIPLE SOURCE DRUGS

Reimbursement for covered multiple-source drugs in the Medicaid program shall be limited to the lowest of:

- (1) The Federally-mandated upper limit of payment or South Carolina Maximum Allowable Costs (SCMAC), for the drug less the current discount rate (10%), plus the current dispensing fee; or
- (2) The South Carolina Estimated Acquisition Cost (SCEAC) which is the average wholesale price (AWP) less the current discount rate (10%), plus the current dispensing fee; or
- (3) The provider's usual and customary charge to the public for the prescription as written for the brand actually dispensed.

B. OTHER DRUGS

Reimbursement for covered drugs other than the multiple-source drugs with CMS upper limits shall not exceed the lower of:

- (1) The South Carolina Estimated Acquisition Cost (SCEAC), which is the average wholesale price (AWP), less the current discount rate (10%), plus the current dispensing fee; or
- (2) The provider's usual and customary charge to the public for the prescription as written for the brand actually dispensed.

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B. SOUTH CAROLINA ESTIMATED ACQUISITION COST (SCEAC)

SCEAC is defined as the State's closest estimate to the price generally and currently paid by providers for specific drugs, based on the package size of drugs most frequently purchased by providers. EAC established by South Carolina is the AMP (Average Wholesale Price) minus 10%. The AMP used in calculating the SCEAC is furnished by a contracted pricing source.

3. MULTIPLE SOURCE DRUG REIMBURSEMENT LIMITATION/PHYSICIAN OVERRIDE

A physician may prescribe a brand name of a multiple source drug that bears a higher cost than the upper limit established by HCFA or South Carolina but reimbursement is available only if the prescription has the physician's certification (in his own handwriting) that the specific brand is medically necessary for a patient. The prescriber must also complete a South Carolina Medicaid Medwatch form documenting that the treatment failure is attributed to the generic product.

4. CO-PAYMENT FOR PRESCRIPTIONS:

[There is a standard co-payment of \$3.40 per prescription (42 CFR 447.55) when co-payment is applicable (42 CFR 447.53). Prescriptions filled by dispensing physicians are not subject to co-payment.]

5. DISPENSING FEE:

Dispensing fees are determined on the basis of surveys that are conducted periodically and take into consideration pharmacy operational costs (overhead, professional services, and profit in different types of pharmacies).

The current dispensing fee is \$4.05 for independent pharmacy providers; \$3.15 for institutional pharmacy providers; no dispensing fee for dispensing physicians.

Dispensing fees are paid to the following type providers:

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"Free-Standing contracting pharmacies not otherwise reimbursed by Medicaid for others service on a cost basis.

"In-House" pharmacies reimbursed by Medicaid on a cost basis for other services.

Dispensing physicians are reimbursed only for the cost of the drug.

Additional Upper Limit Application:

The upper limits are described in this Attachment Section also apply in cases where prescribed drugs are furnished as part of SNF or ICF services or under prepaid capitation arrangements. Contracts between the State Agency and the underwriter, carrier, foundation, HMO or other insurers containing the terms of such prepaid capitation arrangements shall include a provision imposing the same upper limits for reimbursement or prescribing drugs.

12.c Prosthetic Devices and Medical Supplies, Equipment and Services:

Certain medical services, supplies, and equipment (including equipment servicing) that do not generally vary significantly in quantity will be reimbursed at a rate not to exceed the rate established by the Medicare carrier in the area at the lowest charge level at which the service, supplies, and equipment are widely and consistently available within their locality according to the procedures prescribed in 42 CFR 405.511. A list of these items of service is published in the federal regulations. This upper limit is applicable to such services furnished under both Medicare and Medicaid.

For selected services and items furnished only under Medicaid (and identified and published by the Secretary of HHS by regulations), the Medicaid agency must calculate the lowest charge levels under the procedures specified in 42 CFR 405.511© and (d), and limit payments to that amount.

Effective February 1, 2009 there is a standard co-payment (42 CFR 447.55) of \$.60 - 3.40 for Durable Medical Equipment services furnished when co-payment is applicable (42 CFR 447.53). Pregnant women, individuals participating in family planning services, infants and children up to age 19 will not be subject to co-pay.

Hearing Aids - A consolidated contract between the Department of Health and Human Services (DHHS) and Department of Health and Environmental Control (DHEC) is in effect to provide hearing aids, accessories and repair to eligible Medicaid recipients 21 years old and under using S-codes.

Home Dialysis - Reimbursement for equipment and supplies are included in the all inclusive rate paid only to the End Stage Renal Dialysis Clinic.

12.d Eyeglasses

Services are provided under a sole source contract. Reimbursement is based on competitive bid. The duration of the contract is one year.

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