DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Singleton	3-27-12

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 10380	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR _____ cc: Murdock, Deps, CMS file, Chavis	[ ] Prepare reply for appropriate signature DATE DUE _____ [ ] FOIA DATE DUE _____ [X] 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 Street, SW, Suite 4T20
Atlanta, Georgia 30303-8909

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

March 20, 2012

Mr. Anthony E. Keck, 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 #11-024

Dear Mr. Keck:

We have reviewed the proposed amendment to the South Carolina Medicaid State Plan transmittal #11-024 that was received in the Regional Office on December 22, 2011. This State plan amendment updates the hospital specific multiplier with the effective date of October 1, 2011. This multiplier is necessary to comply with the hospital fiscal year end outpatient hospital cost to charge ratios that were adjusted to take into account the effect of the April 8, 2011 or July 11, 2011 payment reductions that are currently outlined in the current approved 4.19B state plan pages. Also, this amendment exempts all SC large rural hospitals as defined by Rural/Urban commuting area classes with total licensed beds of 90 or less as exempt from the July 11, 2011 payment reductions.

Based on the information provided, we are now ready to approve the Medicaid State Plan Amendment SC 11-024. This SPA was approved on March 19, 2012. The effective date of this amendment is October 1, 2011. We are enclosing the approved form HCFA-179 and plan pages.

If you have any questions, please contact Yvette Moore at 404-562-7327.

Sincerely,

Jackie Glaze

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

Enclosures

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 11-024

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
October 1, 2011

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 Part 447 Subpart C

7. FEDERAL BUDGET IMPACT: FMAP, 70.24%
a. FFY 2012 $3.9 million
b. FFY 2013 $3.9 million

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-B, pages 1, 1.1, 1a, 1a.1,1a.2, 1a.3 and 1d

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Attachment 4.19-B, pages 1, 1.1, 1a, 1a.1,1a.2, 1a.3 and 1d

10. SUBJECT OF AMENDMENT:
Update hospital specific outpatient multipliers effective October 1, 2011

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:
December 22 , 2011

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:
12/22/11

18. DATE APPROVED:
03/19/12

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
10/01/11

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

22. TITLE: Associate Regional Administrator
Division of Medicaid & Children Health Opns

23. REMARKS:

Approved with the following changes to item 8 and 9 as authorized by State Agency on email dated 02/13/12.

Block #8 changed to read: Attachment 3.1-A, page 1; 4.19-B, pages 1, 1.1, 1a, 1a.1, 1a.2, 1a.3 and 1d

Block #9 changed to read: Attachment 3.1-A, page 1; 4.19-B, pages 1, 1.1, 1a, 1a.1, 1a.2, 1a.3 and 1d

State/Territory: South Carolina

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SEVICES SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

1. Inpatient hospital services other than those provided in an institution for mental diseases.

☒ Provided: ☐ No limitations ☒ With limitations*

2.a. Outpatient hospital services.

☒ Provided: ☒ No limitations ☐ With limitations*

b. Rural health clinic services and other ambulatory services furnished by a rural health clinic.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not Provided:

c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub.45-4).

☒ Provided: ☐ No limitations ☒ With limitations*

d. Ambulatory services offered by a health center receiving funds under section 329, 330, or 340 or the Public Health Service Act to a pregnant woman or individual under 21 years of age.

☒ Provided: ☒ No limitations ☐ With limitations*

e. Indian Health Service Facility Services.

☒ Provided: ☐ No limitations ☒ With limitations*

3. Other laboratory and x-ray services.

☒ Provided: ☐ No limitations ☒ With limitations*

*Description provided on attachment

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF SOUTH CAROLINA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE
(Reference Attachment 3.1-A)

2.a. OUTPATIENT HOSPITAL SERVICES

I. General Provisions

A. Outpatient Hospital Reimbursement and Upper Payment Limit (UPL) Provision

This plan establishes the methods and standards for reimbursement of outpatient hospital services effective October 1, 2007. Under this plan, a retrospective reimbursement system will be available for the following qualifying hospitals:

- Effective for services provided on or after July 11, 2011, all SC general acute care hospitals except those designated as SC critical access hospitals, SC isolated rural and small rural hospitals, certain SC large rural hospitals which must be located in a Health Professional Shortage Area (HPSA) for primary care for total population, and qualifying burn intensive care unit hospitals which contract with the SC Medicaid Program will receive retrospective cost settlements, that, when added to fee for service and non fee for service payments (i.e. interim estimated cost settlements paid via gross adjustments), will represent ninety-three percent (93%) of each hospital's allowable SC Medicaid outpatient costs which includes both base costs as well as all capital related costs except for the capital associated with Direct Medical Education (DME). The DME cost component of these SC general acute care hospitals with interns/residents and allied health alliance training programs will be retrospectively cost settled at eighty-seven.three percent (87.3%) of allowable SC Medicaid outpatient hospital DME costs (including the DME capital related costs).

- Effective for services provided on or after July 11, 2011, SC general acute care hospitals designated as SC critical access hospitals or those identified as SC isolated rural and small rural hospitals as defined by Rural/Urban Commuting Area classes will continue to receive retrospective cost settlements that represent ninety-seven percent (97%) of allowable SC Medicaid outpatient costs which includes base, capital and DME costs. Additionally, certain SC large rural hospitals as defined by Rural/Urban Commuting Area classes and are located in a Health Professional Shortage Area (HPSA) for primary care for total population will continue to receive ninety-seven percent (97%) of allowable SC Medicaid outpatient costs which includes base, capital and DME costs.

- Effective for services provided on or after October 1, 2011, SC large rural hospitals as defined by Rural/Urban Commuting area classes will receive retrospective cost settlements that represent ninety-seven percent (97%) of allowable SC Medicaid outpatient costs which includes base, capital and DME costs.

- All qualifying hospitals that employ a burn intensive care unit and contract with the SC Medicaid Program will receive an annual retrospective cost settlement for outpatient services provided to SC Medicaid patients. Effective for services provided on or after July 11, 2011, the retrospective cost settlement amount for qualifying hospitals with a burn intensive care unit will continue to be limited to ninety-seven percent (97%) of allowable SC Medicaid outpatient costs which includes base, capital, and DME costs. In order for a hospital to qualify under this scenario, a hospital must:

  a. Be located in South Carolina or within 25 miles of the South Carolina border;

  b. Have a current contract with the South Carolina Medicaid Program; and

  c. Have at least 25 beds in its burn intensive care unit.

- All other hospitals that contract with the SC Medicaid Program for outpatient hospital services will receive prospective payment rates from the statewide outpatient hospital fee schedule. However, effective for services provided on or after July 11, 2011 by contracting out of state border hospitals that have SC Medicaid fee for service inpatient claims utilization of at least 200 claims, an annual analysis will be performed each cost reporting year to ensure that Medicaid reimbursement under the statewide outpatient hospital fee schedule does not exceed ninety-three percent (93%) of allowable SC Medicaid outpatient costs relating to base as well as all capital related costs except for the capital associated with DME. DME costs (including the capital related portion) associated with interns/residents and allied health alliance training programs will no longer be considered an allowable Medicaid reimbursable cost for out of state border hospitals. For outpatient hospital services provided by SC long term acute care hospitals beginning on or after July 11, 2011, an annual analysis will be performed each cost reporting year to ensure that Medicaid reimbursement under the statewide outpatient hospital fee schedule does not exceed ninety-three percent (93%) of allowable SC Medicaid outpatient costs relating to base as well as all capital related costs except for the capital associated with DME. The DME cost component of the SC long term acute care hospitals associated with interns/residents and allied health alliance training programs will be recognized at eighty-seven.three percent (87.3%) of allowable SC Medicaid outpatient hospital DME costs (including the DME capital related portion) in this analysis.

Determination of the Statewide Outpatient Hospital Fee Schedule Rates:

The October 1, 2007 statewide outpatient hospital fee schedule rates for acute care and long term acute care hospitals will be based upon the allowable outpatient cost information of covered services from each acute care hospital's FY 2005 cost report. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of outpatient hospital services. The agency's fee schedule rate was set as of October 1, 2007 and is effective for services provided on or after that date. All rates are published on the agency's website. All contracting SC acute care hospitals as well as out of state contracting border hospitals with SC Medicaid fee for service inpatient claims utilization of at least 200 claims were used in this analysis. The source document for Medicaid allowable outpatient costs will be the CMS-2552, which is the Medicare/Medicaid cost report. Allowable Medicaid outpatient costs will be determined in accordance with the Provider Reimbursement Manual Publication 15. However, for clarification purposes, one hundred

percent (100%) of the South Carolina general acute care hospital provider tax will be considered an allowable Medicaid cost. Outpatient allowable costs, charges and statistics will be extracted from the cost report and prepared for the rate computations using the following general guidelines. The FY 2005 SCDHHS MARS paid claims summary data report for each acute care hospital identified above will also be used during the analysis.

- As filed total facility costs are identified from each facility's FY 2005 Worksheet B Part I (BI) CMS-2552 cost report. Total outpatient facility costs would include operating, capital, and direct medical education. CRNA costs identified under BI, column 20 are removed from allowable costs. Observation cost is reclassified.

- As filed total facility costs will be allocated to Medicaid outpatient hospital cost using the following method:

  A cost-to-charge ratio for each ancillary service will be computed by dividing total costs as adjusted in this section by total charges as reported on Worksheet C. This cost-to-charge ratio will then be multiplied by SC Medicaid covered charges (as reported on Worksheet D Part V for Medicaid outpatient ancillary charges) to yield total SC Medicaid outpatient ancillary costs. The SC Medicaid outpatient cost-to-charge ratio will be determined by taking the sum of the SC Medicaid outpatient ancillary costs and dividing this amount by the sum of the SC Medicaid outpatient covered ancillary charges. The SC Medicaid outpatient cost-to-charge ratio will then be multiplied by the facility's SC Medicaid covered outpatient charges as identified on the SCDHHS MARS summary paid claims data report to determine each hospital's allowable SC Medicaid outpatient cost for FY 2005.

- The allowable Medicaid outpatient costs are summed to determine the aggregate Medicaid outpatient costs for FY 2005. An aggregate Medicaid allowable cost target was established at 95% of allowable Medicaid outpatient costs.

- After establishing the FY 2005 aggregate Medicaid allowable cost target, several actuarial models were developed and FY 2005 outpatient claims were repriced to determine the uniform increase in the statewide outpatient fee schedule rates. In order to trend the rates to the period October 1, 2007 through September 30, 2008, a 3.5% annual trend factor was applied. As a result of these steps, the statewide outpatient fee schedule rates increased by 135% effective October 1, 2007.

  Determination of Hospital Specific Outpatient Multipliers:
  In order to convert the statewide outpatient fee schedule rate payment into a hospital specific payment, an outpatient multiplier will be developed for each hospital. The outpatient multiplier will adjust the calculated statewide outpatient fee schedule claims payment to a hospital specific payment and will represent the projected outpatient costs calculated in accordance with Agency defined criteria effective October 1, 2011 and incorporate the impact of the July 11, 2011 payment reductions for the classes of hospitals outlined in this and the following two paragraphs. Hospitals that receive a hospital specific outpatient multiplier will be those eligible to receive retrospective cost settlements and those contracting out of state border hospitals that have S C Medicaid fee for service inpatient claims utilization of at least 200 claims. However, the outpatient multiplier for the contracting out of state border hospitals identified above will be set at an amount that

will represent 70% of projected October 1, 2011 SC Medicaid outpatient hospital costs. Effective for services provided by contracting out of state border hospitals on or after July 11, 2011, projected allowable Medicaid outpatient hospital costs will be reduced to account for DME costs (including the capital related costs) no longer being reimbursed to contracting out of state border hospitals.

Effective for services provided on or after October 1, 2011, all SC general acute care hospitals except those designated as SC critical access hospitals, SC isolated rural and small rural hospitals, certain SC large rural hospitals located in a Health Professional Shortage Area (HPSA) for primary care for total population, SC large rural hospitals as defined by Rural/Urban Commuting Area classes with total licensed beds of 90 or less and qualifying burn intensive care unit hospitals which contract with the SC Medicaid Program will have its October 1, 2011 hospital specific outpatient multiplier calculated to reflect the impact of the July 11, 2011 payment reductions (i.e. 93% of allowable Medicaid targeted base costs less DME). Additionally, the hospital specific multipliers of the SC general acute care hospitals identified above with interns/residents and allied health alliance training programs will be further adjusted to account for the allowance of eighty-seven.three percent (87.3%) of allowable SC Medicaid outpatient hospital DME costs (including the DME capital related costs).

Effective for services provided on or after October 1, 2011, all SC general acute care hospitals designated as SC critical access hospitals, SC isolated rural and small rural hospitals, certain SC large rural hospitals located in a Health Professional Shortage Area (HPSA) for primary care for total population, SC large rural hospitals as defined by Rural/Urban Commuting Area classes with total licensed beds of 90 or less and qualifying burn intensive care unit hospitals which contract with the SC Medicaid Program will have its October 1, 2011 hospital specific outpatient multiplier calculated to reflect the impact of the July 11, 2011 payment reductions (i.e. 97% of allowable Medicaid targeted costs including DME).

Effective for services provided on and after July 11, 2011, hospitals that do not qualify for retrospective cost settlements will receive an outpatient multiplier of .93.

The outpatient multiplier will be applied after the fee schedule payment has been calculated prior to any reduction for third party liability or coinsurance.

Clinical Lab Fee Schedule:
Effective October 1, 2010, all outpatient hospital clinical lab services provided by governmental and private hospitals will be reimbursed at one hundred percent (100%) of the 2010 Medicare Clinical Lab Fee Schedule rates for the State of South Carolina. Effective for services provided on or after October 1, 2011, all outpatient hospital clinical lab services except for those provided by hospitals identified as SC critical access hospitals, SC isolated rural and small rural hospitals, certain SC large rural hospitals located in a Health Professional Shortage Area (HPSA) for primary care for total population, SC large rural

hospitals as defined by Rural/Urban Commuting Area classes with total licensed beds of 90 or less or qualifying burn intensive care unit hospitals will be reimbursed at ninety percent (90%) of the 2010 Medicare Clinical Lab Fee Schedule rates for the state of South Carolina. SC critical access hospitals, SC isolated rural and small rural hospitals, certain SC large rural hospitals located in a Health Professional Shortage Area (HPSA) for primary care for total population, SC large rural hospitals as defined by Rural/Urban Commuting Area classes with total licensed beds of 90 or less and qualifying burn intensive care unit hospitals will be reimbursed at ninety-seven percent (97%) of the 2010 Medicare Clinical Lab Fee Schedule rates for the State of South Carolina. Therefore, the hospital specific outpatient multiplier described above will no longer be applied in the determination of outpatient hospital clinical lab services reimbursement.

Retrospective Hospital Cost Settlement Methodology:

The following methodology describes the outpatient hospital retrospective cost settlement process for qualifying hospitals. The source document for Medicaid allowable outpatient costs will be the CMS-2552, which is the Medicare/Medicaid cost report. Allowable Medicaid outpatient costs will be determined in accordance with the Provider Reimbursement Manual Publication 15. However, for clarification purposes, one hundred percent (100%) of the South Carolina General acute care hospital provider tax will be considered an allowable Medicaid costs. Effective October 1, 2010, outpatient hospital clinical lab services will no longer be retrospectively cost settled.

- A cost to charge ratio will be calculated for Medicaid outpatient claims. This ratio will be calculated using cost from worksheet B part I, charges from worksheet C, and Medicaid settlement data from worksheet D part V. For ancillary cost centers, a cost-to-charge ratio will be calculated by dividing cost as reported on worksheet B part I by total charges from worksheet C. Medicaid cost for each ancillary cost center will be determined by multiplying this ratio by Medicaid charges as reported on worksheet D part V. Charges not covered by the hospital payment system, such as CRNA and ambulance, must be excluded from this calculation. Effective for services provided on or after July 11, 2011, two cost to charge ratios will be determined for teaching hospitals. The first cost to charge ratio will be determined on base and all capital related costs except those associated with DME capital costs using the methodology previously described. The second cost to charge ratio will be determined using DME costs only (including the capital portion of DME costs) using the methodology previously described. The applicable reductions (i.e. 93% or 97% to base and capital and 0% or 87.3% to DME) will be applied to the calculated cost for each cost pool and an adjusted cost/charge ratio will be determined.

- Total allowable Medicaid cost will be determined at the time of cost settlement by multiplying the adjusted cost to charge ratio as calculated above, by Medicaid adjusted charges. Medicaid adjusted charges will be adjusted for non Mars Report adjustments such as claim refunds, third party recoveries, etc. This adjustment is calculated by multiplying the ratio of Mars Report covered charges to Mars Report covered payments by the sum of the non Mars Report adjustment amounts. This amount is subtracted (debit) or added (credit) as appropriate.

- The interim retrospective cost settlement amount will be determined by subtracting payments received from the allowable adjusted cost determined above. The payment amount includes Mars report payments and non Mars Report adjustments that were processed during the cost reporting/settlement period. Examples of these adjustments are refunds associated with third party payments, interim cost settlement payments, etc.

Interim estimated cost settlements will only be allowed in extraordinary circumstances. It will be the responsibility of the provider to request and document the need for the interim cost settlement which could include the submission of one, or a combination of, the following documentation:

a. a more current annual or a less than full year Medicare/Medicaid cost report;
b. an updated outpatient cost-to-charge ratio;
c. an analysis reflecting the financial impact of the reimbursement change effective for services provided on and after October 1, 2011.

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.

For clarification purposes, all interim retrospective cost settlements will be subject to final audit. Any underpayment/(overpayment) identified as a result of the final audit will be paid or recouped accordingly.

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:

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:

b. Fees for non-surgical classifications are based on a relationship to the average historical payment made by the state of such procedures as determined from claim history data. ICD-9-CM diagnostic procedure codes which are not classified under the initial grouping of procedures will be assigned a class by the Commission. Professional medical personnel will be responsible for this function.

A procedure may be assigned to an existing classification or a new classification may be created to compensate for the procedure at the discretion of DHHS.

c. In the case of multiple diagnosis only one payment will be made. The class producing the highest rate of payment will be selected as the payment rate.

C. Treatment/Therapy/Testing Services

The methods and standards for payment of treatment/testing/therapy services are divided into two categories:

- Laboratory and Radiology
- Other Treatment, Therapy and Testing Services

1. Laboratory and Radiology

a. Services Included in Payment Amount

Payment for laboratory and radiology services rendered to outpatients shall consist of a fee for services. Effective October 1, 2010, all outpatient hospital clinical lab services will be reimbursed at one hundred percent (100%) of the 2010 Medicare Clinical Lab Fee Schedule rates for the State of South Carolina. Effective for services provided on or after October 1, 2011, all outpatient hospital clinical lab services except for those provided by hospitals identified as SC critical access hospitals, SC isolated rural and small rural hospitals, certain SC large rural hospitals located in a Health Professional Shortage Area (HPSA) for primary care for total population, SC large rural hospitals as defined by Rural/Urban Commuting Area classes with total licensed beds of 90 or less or qualifying burn intensive care unit hospitals will be reimbursed at ninety percent (90%) of the 2010 Medicare Clinical Lab Fee Schedule rates for the state of South Carolina. SC critical access hospitals, SC isolated rural and small rural hospitals, certain SC large rural hospitals located in a Health Professional Shortage Area (HPSA) for primary care for total population, SC large rural hospitals as defined by Rural/Urban Commuting Area classes with total licensed beds of 90 or less and qualifying burn intensive care unit hospitals will be reimbursed at ninety-seven percent (97%) of the 2010 Medicare Clinical Lab Fee Schedule rates for the State of South Carolina, The fee excludes payment for services rendered directly to a patient by a physician (professional).

b. Payment Method

i. Payments for technical radiology and laboratory services shall be made based on the lesser of the charge or fixed fee for each CPT coded procedure.

2. Other Treatment, Therapy and Testing Services

a. Services Included In Payment Amount

Treatment, therapy, and testing services under this part include dialysis treatment, respiratory, physical, speech, occupational, audiological therapies, psychiatric treatment and testing. The payment for each treatment and testing category is a payment per service. Therapy services rendered under this part include the professional services component. If such services are provided in conjunction with surgical or non-surgical services, no separate payment shall be made.

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 12-010

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
August 1, 2012

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 CRF 455 Subpart E

7. FEDERAL BUDGET IMPACT:
a. FFY N/A $
b. FFY N/A $

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Basic Text Page 79z, 79z.1

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

10. SUBJECT OF AMENDMENT:

Medicaid/CHIP Provider Enrollment and Screening

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:

South Carolina Department of Health and Human Services
Post Office Box 8206
Columbia, South Carolina 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:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: South Carolina

4.46 Provider Screening and Enrollment

Citation	
1902(a)(77) 1902(a)(39) 1902(kk); P.L. 111-148 and P.L. 111-152	The State Medicaid agency gives the following assurances:
42 CFR 455 Subpart E	PROVIDER SCREENING __X__ Assures that the State Medicaid agency complies with the process for screening providers under section 1902(a)(39), 1902(a)(77) and 1902(kk) of the Act.
42 CFR 455.410	ENROLLMENT AND SCREENING OF PROVIDERS __X__ Assures enrolled providers will be screened in accordance with 42 CFR 455.400 et seq. __X__ Assures that the State Medicaid agency requires all ordering or referring physicians or other professionals to be enrolled under the State plan or under a waiver of the Plan as a participating provider.
42 CFR 455.412	VERIFICATION OF PROVIDER LICENSES __X__ Assures that the State Medicaid agency has a method for verifying providers licensed by a State and that such providers licenses have not expired or have no current limitations.
42 CFR 455.414	REVALIDATION OF ENROLLMENT __X__ Assures that providers will be revalidated regardless of provider type at least every 5 years.
42 CFR 455.416	TERMINATION OR DENIAL OF ENROLLMENT __X__ Assures that the State Medicaid agency will comply with section 1902(a)(39) of the Act and with the requirements outlined in 42 CFR 455.416 for all terminations or denials of provider enrollment.
42 CFR 455.420	REACTIVATION OF PROVIDER ENROLLMENT __X__ Assures that any reactivation of a provider will include re-screening and payment of application fees as required by 42 CFR 455.460.

42 CFR 455.422

APPEAL RIGHTS

___X_ Assures that all terminated providers and providers denied enrollment as a result of the requirements of 42 CFR 455.416 will have appeal rights available under procedures established by State law or regulation.

42 CFR 455.432

SITE VISITS

___X_ Assures that pre-enrollment and post-enrollment site visits of providers who are in "moderate" or "high" risk categories will occur.

42 CFR 455.434

CRIMINAL BACKGROUND CHECKS

___X_ Assures that providers, as a condition of enrollment, will be required to consent to criminal background checks including fingerprints, if required to do so under State law, or by the level of screening based on risk of fraud, waste or abuse for that category of provider.

42 CFR 455.436

FEDERAL DATABASE CHECKS

___X_ Assures that the State Medicaid agency will perform Federal database checks on all providers or any person with an ownership or controlling interest or who is an agent or managing employee of the provider.

42 CFR 455.440

NATIONAL PROVIDER IDENTIFIER

___X_ Assures that the State Medicaid agency requires the National Provider Identifier of any ordering or referring physician or other professional to be specified on any claim for payment that is based on an order or referral of the physician or other professional.

42 CFR 455.450

SCREENING LEVELS FOR MEDICAID PROVIDERS

___X_ Assures that the State Medicaid agency complies with 1902(a)(77) and 1902(kk) of the Act and with the requirements outlined in 42 CFR 455.450 for screening levels based upon the categorical risk level determined for a provider.

42 CFR 455.460

APPLICATION FEE

__X__ Assures that the State Medicaid agency complies with the requirements for collection of the application fee set forth in section 1866(j)(2)(C) of the Act and 42 CFR 455.460.

42 CFR 455.470

TEMPORARY MORATORIUM ON ENROLLMENT OF NEW PROVIDERS OR SUPPLIERS

___X_ Assures that the State Medicaid agency complies with any temporary moratorium on the enrollment of new providers or provider types imposed by the Secretary under section 1866(j)(7) and 1902(kk)(4) of the Act, subject to any determination by the State and written notice to the Secretary that such a temporary moratorium would not adversely impact beneficiaries' access to medical assistance.