DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

EA

ACTION REFERRAL

TO	DATE
Charis Singleton	7/16/14

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 000024	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR CC: Director, Deps, Kost	[ ] 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

July 9, 2014

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

Attention: Sheila Chavis

RE: Title XIX State Plan Amendment, SC 11-020

Dear Mr. Keck:

We have reviewed the proposed State Plan Amendment, SC 11-020, which was submitted to the Atlanta Regional Office on December 8, 2011. This state plan was submitted in response to SC-11-005 companion letter which was issued on June 23, 2011. The purpose of this plan is to add reimbursement language to the following services: Other Laboratory and X-ray services; Early and Periodic Screening, Diagnosis and Treatment Screening Services (EPSDT); Family Planning Services and Supplies; and Preventive Services.

Based on the information provided, the Medicaid State Plan Amendment SC 11-020 was approved on July 9, 2014. The effective date of this amendment is October 1, 2011. We are enclosing the approved HCFA-179 and the plan pages.

If you have any additional questions or need further assistance, please contact Maria Drake at (404) 562-3677 or Cheryl Wigfall at (803) 252-7299.

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 11-020

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
10/01/11

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 440 Subpart A

7. FEDERAL BUDGET IMPACT: FMAP
a. FFY 2011 $
b. FFY 2012 $

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 3.1-A, pages 6 & 8a
Attachment 3.1-A, Limitation Supplement, pages 3a, 3a.1,4a, 6, and 6.1
Attachment 4.19-B, pages 2, 2a.2, 2b, 3 and 6

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Attachment 3.1-A, pages 6 & 8a
Attachment 3.1-A, Limitation Supplement, pages 3a, 3a.1,4a, & 6
Attachment 4.19-B, pages 2, 2a.2, 2b, 2.b1, 2.c, 3 and 6
(Pages 2b.1 & 2c should be deleted)

10. SUBJECT OF AMENDMENT:
Companion Letter with approval of SC 11-005. Same Page issues.

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 8, 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:
12-08-11

18. DATE APPROVED: 07-09-14

PLAN APPROVED – ONE COPY ATTACHED

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

20. SIGNATURE OF REGIONAL OFFICIAL:
Jackie Glaze

21. TYPED NAME:
Jackie Glaze

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

23. REMARKS: Approved with the following changes to blocks 8 and 9 as authorized by State Agency on emails dated 06-17-14, 07-01-14 and 07-02-14.

Block #8 changed to read: Attachment 3.1-A Limitation Supplement 3-1-A, Pages 3a.1, 4a, 6, 6.1 and Attachment 3.1-A pages 6 and 8a; Attachment 4.19-B pages 2, 2.a1, 2a.2, 3, 3a and 6.

Block #9 changed to read: Attachment 3.1-A Limitation Supplement 3-1-A, Pages 3a.1, 4a, 6, 6.1(new) and Attachment 3.1-A pages 6 and 8a; Attachment 4.19-B pages 2, 2.a1(new), 2a.2, 3, 3a and 6.

The following services are excluded from coverage:

- Optometric hypnosis
- Broken appointments
- Special reports
- Progressive and transitional lenses
- Lenses and/or frames that are not included in the Medicaid sample kit
- Extended wear contact lenses
- Oversized lenses or frames, unless medically justified
- Tinted lenses and coatings, unless medically justified, as in the case of albinism or post-cataract patients
- Trifocals
- Executive bifocals, unless medically justified
- Bifocal segment widths in excess of 25 mm unless medically justified

Detail clinical policy is published in the Physician, Laboratories, and Other Medical Professional manual on the South Carolina Department of Health and Human Services website at www.scdhhs.gov.

The South Carolina Department of Health and Human Services may approve additional ambulatory care visits when medically necessary. Limitations will be based on medical necessity.

Preventive Care:

Newborn Care is limited to routine newborn care and follow-up in the hospital. All other well baby services are limited to the provisions defined in the EPSDT section of the plan.

Immunizations for recipients over the age of 21 are limited to influenza, pneumonia, meningitis and hepatitis vaccinations for at risk patients as described in the Physician, Clinical and Ancillary Services Manual.

Chiropractic services must conform to policies, guidelines and limitations as specified in the Chiropractic Services Manual. Chiropractic providers are licensed practitioners and provide services within the scope of practice as defined under State law and in accordance with the requirements of CFR 440.60(a)

6.d Other Medical Care or Remedial Care Provided by Other Practitioners

Certified Registered Nurse Anesthetist/AA - Certified Registered Nurse Anesthetist/AA are authorized to perform anesthesia services only. The scope of their practice is limited to that which is allowed under State Law. A copy of their certification must be on file at the practice site.

Nurse Practitioner - Nurse Practitioners are authorized to perform certain services pertaining to their specific approved written protocols. The scope of their practice is limited to that which is allowed under State Law and as documented in written protocol between the nurse practitioners and their physician preceptors. The written protocol must be submitted to SHHSFC prior to enrollment.

Psychologists - Psychological services are covered when prescribed by an EPSDT screen and prior authorization process. Services covered include psychological testing, evaluation and therapy. Reimbursements to practitioners are restricted to psychologists that hold doctoral level diploma, and have a valid state license as a Clinical, psychologist approved by the State Board of Examiners in Psychology.

Licensed Midwife - Medicaid coverage includes all obstetrical services, newborn care and medical services that are published in the South Carolina Medicaid Physician and Clinical Services Manual, with appropriate revisions and updates. All services must be medically justified and rendered in accordance with the standards of care and services prescribed by the appropriate licensing and regulation agency(ies) under the laws of the State of South Carolina.

GENERAL EXCLUSIONS: As provided by Section 1927(d) of the Social Security Act, certain outpatient drugs may be excluded from coverage. Those excluded are:

A. Medications used for weight control (except lipase inhibitors).
B. Pharmaceuticals deemed less than effective by the Drug Efficacy Study Implementation (DESI) Program.
C. Over-the-counter (OTC) pharmaceuticals that are not in the Medicaid drug rebate program and those products that are otherwise excluded from Medicaid coverage in this section.
D. Topical forms of minoxidil when used for hair loss.
E. Agents when used to promote fertility. (Effective March 1, 1991)

As provided by Section 1927(k) (2) of the Social Security Act, certain other exclusions are:

F. Investigational/experimental pharmaceuticals or products without FDA approval under the Federal Food, Drug, and Cosmetic Act.

As provided by Section 1927(k) (3) of the Social Security Act, certain other exclusions are:

G. Injectable table pharmaceuticals administered by the physician in his office, in a clinic or in a mental health center.

Drug Prior Authorizations can be requested by the prescribing physician or pharmacist with needed documentation for items excluded from coverage and those drugs requiring special authorization as outlined in the Pharmaceutical Services Medicaid Manual, except those drugs ruled ineffective (DESI) by the Federal Government.

12c. PROSTHETIC OR ORTHOTIC APPLIANCES. Approval from the State Office is required prior to the provision of the prosthetic or orthotic appliance. Supplies, equipment, and appliance limitations are specified in the Durable Medical Equipment Provider Manual, and follow Medicare limitations.

12d. EYEGLASSES Coverage for eyeglasses will be limited to recipients under 21 years of age when medical necessity has been established. One pair of eyeglasses is available during a 365 day period to beneficiaries eligible under the EPSDT program. Additional lenses can be approved if the prescription changes at least one half diopter (0.50) during the 365 day period.

13b. Preventive Services are further limited to specific cancer screening procedures as listed for the following at risk patients without diagnostic indicators:

1. Mammography Baseline: age 35-39, One every other year: age 40-50, One every year: age 50-up.

2. Pap Smear - One per year: age in conjunction with onset of menses.

3. Hemoccult Test One per year: age 50-up for low risk clients: age 40-up for high risk clients.

4. Sigmoidoscopy One per five years: age 50 up for low risk clients; age 40 up for high risk clients.

5. Colonoscopy One per ten years: age 50 up for low risk clients; age 40 up for high risk clients.

13c. PREVENTIVE SERVICE FOR PRIMARY CARE ENHANCEMENT

A. Definition of Service - Preventive Services for Primary Care Enhancement (PSPCE) are services, including assessment and evaluation, furnished by physicians or other licensed practitioners of the healing arts acting within the scope of practice under State law which are furnished in order to:

- Prevent disease, disability, and other health conditions or their progression;
- Prolong life; and
- Promote physical and mental health and efficiency.

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

b. Screening Services.

☒ Provided: ☐ No limitations ☒ With limitations*

☐ Not Provided

c. Preventive Services.

☒ Provided: ☐ No limitations ☒ With limitations*

☐ Not Provided

d. Rehabilitative services.

☒ Provided: ☐ No limitations ☒ With limitations*

☐ Not Provided

14. Services for individuals age 65 or older in institutions for mental diseases.

a. Inpatient hospital services.

☐ Provided: ☐ No limitations ☐ With limitations*

☒ Not Provided

b. Nursing facility services.

☒ Provided: ☐ No limitations ☒ With limitations*

☐ Not Provided

*Description provided on attachment.

State/Territory: South Carolina

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

21. Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by a qualified provider (in accordance with section 1920 of the Act).

☐ Provided: ☐ No limitations ☐ With limitations*

☒ Not provided:

22. Respiratory care services (in accordance with section 1902(e)(9)(A) through (C) of the ACT).

☐ Provided: ☐ No limitations ☐ With limitations*

☒ Not provided:

23. Pediatric or family nurse practitioners' services.

☒ Provided: ☒ No limitations ☐ With limitations*

☐ Not provided:

NOTE: South Carolina License Board does not license families pediatric nurse practitioners. However, nurse practitioners are covered at Attachment 3.1-A, Limitation Supplement, Page 4a, Section 6d.

*Description provided on attachment.

both programs; however, The Medicare (Title XVII) program is primarily responsible for reimbursement in these cases. Non-Medicare benefits will follow the South Carolina Medicaid State Plan as described in 42 CFR 337.371 (c) (2).

3. Other Laboratory and X-Ray Services:

The Physician Services fee schedule rates are effective for services provided on or after the implementation date as outlined in the Physician Services methodology located at Attachment 4.19-B, Page 2a.2 Section 5. Medicaid bulletins informing the providers of the fee schedule rate changes, as well as the fee schedule itself, are available on the agency's website at http://www.scdhhs.gov/ServiceProviders/FeeSchedules.asp. .

4.b Early and Periodic Screening, Diagnosis and Treatment Screening Services:

Reimbursement for Early and Periodic Screening, Diagnosis and Treatment Screening Services are reimbursed based on the Physician Services fee schedule rates effective for services provided on or after the implementation date as outlined in the Physician Section 5, Attachment 4.19-B, Page 2a.2. Medicaid Bulletins informing the providers of the fee schedule rate changes, as well as the fee schedule itself, are available on the agency's website at http://www.scdhhs.gov/ServiceProviders/FeeSchedules.asp.

Comprehensive Health and Developmental History including
Assessment of both Physical and Mental Health Development

Assessment of Nutritional Status	Vision Screening
Comprehensive Unclothed Physical Examination	Hearing Screening
Ear, Nose, Mouth and Throat Inspection	Blood Pressure
Developmental Assessment	Anemia Screening
Assessment of Immunization Status and Administration	Health Education

Optional services as deemed medically necessary by the provider:

Lead Screening	Tuberculin Skin Test	Urinalysis
Sickle Cell Test	Parasite Test	

Immunizations:

Vaccines for Children Program. The appropriate Immunization Administration for Vaccine/Toxoids Current Procedural Terminology code will be reimbursed to Medicaid providers who administer immunizations in conjunction with an EPSDT screening or other billable service, as well as, for "shots only" visits. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The reimbursement for this service can be found at the Physician Services fee schedule effective for services provided on or after the implementation date as outlined in the Physician Services methodology located at Attachment 4.19-B, Page 2a.2 Section 5. Medicaid Bulletins informing the providers of the fee schedule rate changes, as well as the fee schedule itself, are available on the agency's web site at http://www.scdhhs.gov/ServiceProviders/FeeSchedules.asp.

Payments for EPSDT Services that are not otherwise covered:

Services not listed as covered services in the state agency manuals/state plan will be provided if determined to be medically necessary by the appropriate agency staff or consultants. The reimbursement rate for these services will

be 80% of statewide usual and customary fees. These are services that are not covered by South Carolina Medicaid and are not listed in any fee schedule. Several methodologies are employed to determine the appropriate reimbursement. The sequence that is employed is listed below:

a) If the service has a Medicare established reimbursement or a Resource Based Relative Value Scale (RBRVS) value, the reimbursement is calculated based on the established methodology used in Section 5 (Physician Services) on Page 2a.2.

b) If neither a Medicare rate nor an RBRVS rate exists and the procedure is covered by the State of South Carolina employee Health plan, a percentage of this rate is used to reimburse for the service.

c) If neither a Medicare rate nor an RBRVS rate exists and the procedure is not covered by the State of South Carolina employee Health plan, we would negotiate a percentage of charges with the provider to cover this procedure.

Home Based Private Duty Nursing Services:

Home Based Private Duty Nursing reimbursement rates are separately established for Registered Nurses (RN) and Licensed Practical Nurses (LPN). Salaries, fringe benefits, limited direct, and indirect costs are considered in the development of the rates. Services are billed in 6-minute increments; therefore, ten (10) units equate to an hour of care.

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:

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. Family Planning Services are reimbursed at an established fee schedule based on the methodologies set forth in Attachment 4.19B, Page 2a.2, Section 5 Physician Services and Attachment 4.19B Page 3b Section 12 Prescribed Drugs. The Physician Services fee schedule rates are effective for services provided on or after the implementation date as outlined in the Physician Section 5, Attachment 4.19-B. Medicaid Bulletins informing the providers of the fee schedule rate changes, as well as the fee schedule itself, are available on the agency's website at http://www.scdhhs.gov/ServiceProviders/FeeSchedules.asp.

5. Physician Services:

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. The agency's fee schedule rates were set as of October 1, 2009 and are effective for services provided on or after that date. Medicaid Bulletins informing the providers of the fee schedule rate changes, as well as the fee schedule itself, are available on the agency's web site at http://www.scdhhs.gov/ServiceProviders/FeeSchedules.asp. See page 0 of Attachment 4.19-B. All physician services will be reimbursed based on a Fee Schedule that in the aggregate will not exceed 100 percent of Medicare.

Payment to pediatric subspecialists (excluding Neonatologists) are paid 116.4 percent of the 2009 SC Medicare Fee Schedule. This rate was last updated on July 11, 2011. Payment to Neonatologists are paid 115 percent of the 2009 SC Medicare Fee Schedule. This rate was last updated on April 8, 2011. See page 0 of Attachment 4.19-B.

Family and general practice physicians, osteopaths, internal medicine physicians, pediatricians, and geriatricians are paid 81 percent of the 2009 Medicare Fee Schedule. This rate was last updated on July 11, 2011. See page 0 of Attachment 4.19-B.

Anesthesiologists are paid 81 percent of the 2009 SC Medicare Fee Schedule. This rate was last updated on July 11, 2011. See page 0 of Attachment 4.19-B.

6.a Podiatrists' Services:

Reimbursement is calculated in the same manner as for Physicians' services. Refer to the Physician Services Section 5, in Attachment 4.19-B.

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

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:

Reimbursement is calculated in the same manner as for Physicians' services. Refer to the Physician Services Section 5, in Attachment 4.19-B.

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 the Physician Services Section 5, in Attachment 4.19-B.

Nurse Practitioner: Reimbursement is calculated at 80 percent of the rate for Physician Services. Refer to the Physician Services Section 5, in Attachment 4.19-B.

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

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 Medicaid costs, charges, or the Medicaid cost limits as defined in the plan that are based upon Medicare allowable cost definitions and 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. For all equipment and supplies not routinely provided during the course of a Home Health visit and purchased through a home health agency, the agency will be reimbursed in accordance with Section 12 c of this plan 4.19-B. The payment rate for DME is based on a state specific fee schedule. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The rate was last updated on July 11, 2011. 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.

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 in section 9, Clinical Services, have been established to provide adequate payments to the providers of these services.

End Stage 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.

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 2a.2 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:

13.b The cancer screening services are reimbursed on the Physician Services fee schedule. The Physician Services fee schedule rates are effective for services provided on or after the implementation date as outlined in the Physician Section 5, Attachment 4.19-B. Medicaid Bulletins informing the providers of the fee schedule rate changes, as well as the fee schedule itself, are available on the agency's web site at http://www.scdhhs.gov/ServiceProviders/FeeSchedules.asp.

13.c Preventive Services

Preventive services for Primary Care Enhancement as defined in 3.1-A, pages 6 and 6a, paragraph 13c. must be provided by a physician or other licensed practitioner of the healing arts as required by 42 CFR 440.130(c). The following services will be reimbursed by Medicaid as a preventive service for Primary Care Enhancement:

(A) - Individual preventive services for Primary Care Enhancement provided by a professional (unit of service - 15 minutes)
(B) - Group preventive services for Primary Care Enhancement provided by a professional (unit of service - 15 minutes)
(C) - Assessment provided by a professional(unit of service - 15 minutes)

Medicaid reimbursement rates for preventive services for Primary Care Enhancement will be established utilizing Medicare reasonable cost principles, as well as OMB Circular A-87 and other OMB circulars as may be appropriate. For each level of service that is paid for on a per unit basis, budgeted costs will be used in determining the initial rates for each. Budgeted costs may include personnel costs (including fringe benefits), operating costs (such as building and equipment maintenance, repairs, depreciation, amortization, and insurance expenses; employee travel and training expenses; utilities; plus material and supply expenses); as well as indirect costs and general and administrative overhead costs. The initial rates will be determined by dividing the budgeted costs by the projected units of service. However, the initial rate for each level of service can not exceed the maximum rate cap established for each level of service. A unit of service for preventive services for Primary Care Enhancement is defined as fifteen (15) minutes of service delivery.

All providers (i.e., private and public) of preventive services for Primary Care Enhancement will be required to submit annual cost reports for each level of service for which they are reimbursed. The cost reports shall include the actual costs of providing each service level as well as service delivery data utilizing the established defined unit of service. These reports will be used to analyze the appropriateness and reasonableness of the reimbursement rates as well as to verify that the Medicaid reimbursement does not exceed the actual allowable costs of providing services. Cost settlements will be performed each year as a result of the submission of the annual cost reports. However, Medicaid reimbursement will be limited to the lower of actual allowable Medicaid costs or the maximum rate cap established for each level of service. The maximum rate cap for each level of service will be established each year using the financial and service delivery data of the largest volume provider of the service. Additionally, future reimbursement rates for providers will be the lesser of the providers actual unit cost or the maximum rate that has been established.

This reimbursement methodology will expire September 30, 2012.

Preventive Services - Disease Management
The disease management program is a preventive service that provides coverage under the Categorically Needy Program (CNP) to all Medicaid beneficiaries who receive services through the South Carolina Medicaid fee-for-service (FFS) system, including those who have one or more of the following diseases: Asthma, Diabetes, or Hypertension.