In accordance with federal interpretation, the disease management contracts are risk contracts. The method of payment has been developed using actuarially sound methodology per 42 CFR438.6 (c).

The State will pay the DMOs a per member per month capitated fee based on the total eligible population, and the prevalence of each disease within the total population.

The State expects a minimum, annual net cost savings of five percent (5%) in the overall medical costs of those beneficiaries with asthma, diabetes or hypertension. The guaranteed, annual net savings is defined as total savings minus SCDHHS expenditures on disease management services under the contract.

If the amount of guaranteed minimum, annual net savings is not achieved, the DMOs will pay the difference between the guaranteed minimum, annual net savings and the actual net savings to the SCDHHS. The DMOs will also be required to forfeit their fees.

13.d Rehabilitative Services

Rehabilitative behavioral health services are medical or remedial services that have been recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice, under South Carolina State Law and as may be further determined by the South Carolina Department of Health and Human Services (SCDHHS) for maximum reduction of physical or mental disability and restoration of a beneficiary to their best possible functional level. The following services are considered Medicaid Rehabilitative services:

> Behavioral Health Screening, Behavior Modification, Crisis Management, Diagnostic Assessment, Family Therapy, Family Support, Group Therapy, Individual Therapy, Medication Management, Peer Support Services, Rehabilitative Psychosocial Services, Service Plan Development, Substance Abuse Counseling, and Substance Abuse Examination.

In order to develop Medicaid payment rates by provider type (i.e. practitioner) for each service listed above, the Medicaid Agency employed the following reimbursement methodology:

1. First, the agency developed annual compensation amounts for each provider type:

   - Salary data was obtained from the South Carolina Office of Human Resources (SCOHR) Classifications Manual (midpoint per position salary data) as well as the May 2008 South Carolina Occupational Employment and Wage Estimates from the United States Department of Labor (mean salary data). For unclassified professional positions that are not identified within the SCOHR Classification Manual, provider compensation amounts were obtained from applicable providers.

- Provider information reflecting the professionals that would be providing the different rehab services were utilized to match the appropriate SCOHR position classifications. An average of the identified midpoint salary classification was utilized to reflect the public compensation when more than one classification applied to the service.

- Mean salary data obtained from the Department of Labor Survey identified above was utilized to estimate the private compensation levels of each provider type based upon provider information reflecting the professionals that would be providing the different rehab services. An average of the identified mean salary classification was utilized to reflect the private compensation when more than one classification applied to the service.

- To determine the overall average annual compensation amounts for each provider type, the Medicaid Agency simply averaged the annual compensation amounts determined under the public compensation method and the private compensation method.

- After completing the individual average annual compensation level for each provider type, the following provider types were classified under one of the following educational levels to determine an overall average annual compensation amount for each educational level. The provider titles of Psychiatrist, Physician, Pharmacist, Psychologist, Physician Assistant, Advanced Practical Registered Nurse, Registered Nurse, Licensed Practical Nurse are not classified according to educational level but rather establish their own provider specific average annual compensation level.

PROVIDER TYPE	EDUCATIONAL LEVEL
Licensed Independent Social Worker – Clinical Practice (LISW – CP)	Masters Level
Licensed Independent Social Worker – Advanced Practice (LISW – AP)	Masters Level
Licensed Masters Social Worker (LMSW)	Masters Level
Licensed Marriage and Family Therapist (LMFT)	Masters Level
Licensed Professional Counselor (LPC)	Masters Level
Certified Substance Abuse Professional	Masters Level

PROVIDER TYPE	EDUCATIONAL LEVEL
Clinical Chaplain	Masters Level
Mental Health Professional (MHP)	Masters Level
Behavior Analyst- Masters Level	Masters Level
Licensed Bachelor of Social Work (LBSW)	Bachelors Level
Substance Abuse Specialist	Bachelors Level
Behavior Analyst- Bachelors Level	Bachelors Level
Certified Substance Abuse Professional (SAP)	Bachelors Level
Child Service Professional	Bachelors Level
Mental Health Specialist	High School Level
Peer Support Specialist (PSS)	High School Level

- As a result of the above methodology, annual compensation amounts were determined for the following provider types and educational levels: Psychiatrist, Physician, Pharmacist, Psychologist, Physician Assistant, Advanced Practical Registered Nurse, Registered Nurse, Licensed Practical Nurse, Masters Level, Bachelors Level, and High School Level.

2. Next, the Medicaid Agency determined the maximum number of billing hours that could be anticipated for each provider type for each billable service. Assuming a billing productivity factor of 50%, the maximum number of billing hours for each provider type was calculated to be 975 hours. The calculation is as follows – 37.5 hours per week x 52 weeks x 50% = 975 hours.

3. Next, the annual compensation amounts determined in (1) above are divided by the maximum number of billable hours as determined in (2) above to arrive at an hourly billing compensation rate for each provider type.

4. Next, the initial hourly billing compensation rate for each provider type as identified in (3) above is increased by 30% to take into account the cost of fringe benefits. The fringe benefit allocation percentage is representative of state government fringe benefit allowances.

5. Next, once the initial hourly billing compensation rate is increased by the fringe benefit allowance of 30% as determined in (4) above, it is multiplied by an indirect cost rate of 10% to arrive at an adjusted hourly billing rate by provider type. An indirect rate is applied to compensate the provider for overhead costs.

6. Next, once the hourly billing rate has been adjusted for indirect cost as determined in (5) above, a supervision adjustment factor of 10% is then applied to the provider types which require supervision in accordance with the requirements of the Rehabilitative Service definitions as outlined under Attachment 3.1-A. The provider types affected include: Registered Nurses, Licensed Practical Nurses, and all Masters Level, Bachelors Level, and High School Level professionals.
7. Next, in order to account for level of effort of providing specific rehab services by provider type, a work adjustment factor will be applied to the hourly billing rate previously adjusted for provider supervision as determined in step (6). Level of effort is defined based on the work unit component of the 2009 Medicare RBRVS. Level of effort relativity factors were developed by mapping therapy services types based upon the definition of the target service type to the definition of the CPT procedure codes in the applicable procedure code list (as defined by the CPT 2009 Professional Edition, published by the American Medical Association and Stedman's CPT Dictionary, second edition, published by the American Medical Association). The level of effort adjustment was developed by dividing the work units for each of the procedure codes by the overall average work units for the universe of target procedure codes (90804 to 90862, 99367, 99368, and 99204). For several service categories, codes were combined and composite results were utilized. Procedures were grouped for family therapy, assessments, services with evaluation and management components, and services with evaluation and management components. In addition, clinical judgments were made with respect to:
   * For level of effort for service types between physicians and other professional providers relative to para-professionals.
   * For differences between CPT code definitions and the services to be provided.
8. Finally, to determine the Medicaid rate of each provider type for each rehab service that the provider type is authorized to render, the hourly billing rate as determined in step (7) will be divided by each service's unit of measurement.

Psychological Training and Testing services provided by psychologists will be reimbursed at one hundred percent of the 2006 version of the South Carolina Medicare Physician Fee Schedule.

Medication administration services (i.e. injectibles and injectibles administration) rendered in conjunction with certain rehabilitative services identified above will be reimbursed in accordance with the South Carolina Physician Fee Schedule in effect at the time of service.

The Medicaid agency will reimburse private providers of rehabilitative services using Medicaid rates which are calculated in accordance with the rate setting methodology previously described. Also, interim Medicaid

payments for state owned and non-state owned governmental providers of rehabilitative services will be based upon the Medicaid rates previously described by practitioner level. Except as otherwise noted in the plan, state-developed fee schedule rates and unit measures are the same for both governmental and private providers of Rehabilitative Behavioral Health Services. The agency's fee schedule was set as of July 1, 2010 and is effective for services provided on or after that date. All fee schedule rates and unit measures are published at http://www.scdhhs.gov/whatsnew.asp. State owned and non-state owned governmental providers will be reimbursed at one hundred percent of their allowable Medicaid costs based upon the review and reconciliation of annual cost reports.

Annual Cost Identification and Reconciliation Process for State Owned and Non-State Owned governmental providers:

Each State Owned and Non-State Owned governmental provider rendering rehabilitative behavioral health services will be required to submit a CMS approved annual cost report to establish the costs of their services. Allowable costs will be accumulated by practitioner and service definition. Costs by practitioner by service will be accumulated for the total population of users of the service (i.e. regardless of the source of payment). Allowable costs will be classified as follows:

Direct Costs:

1) Directly chargeable salary costs of the practitioner(s) providing the service and associated fringe benefits,
2) Materials, supplies excluding injectibles, and non-capital related equipment expenditures required by the practitioners for the provision of service,
3) Required training and any associated travel costs of the practitioners, and
4) Any costs not noted above but directly assignable excluding subcontract arrangements for direct service delivery and costs included in indirect cost determination.

Supervision:

Costs of supervisory staff will be added to the direct costs associated with practitioners of specific services. Allowability of supervisory costs is determined based on the practitioners requiring supervision in accordance with the Rehabilitative Service definitions as outlined under Attachment 3.1-A. The provider types affected include: Registered Nurses, Licensed Practical Nurses, and all Masters Level, Bachelors Level, and High School Level professionals. Time and effort reports completed in accordance with HIM-15, Chapter 2300, Section 2313.2 (E) will be used to determine supervision costs.

Indirect Costs:

Allowable indirect costs can be determined in one of two ways:

1. The application of the provider's federally approved indirect cost rate (or federally approved cost allocation plan) or

2. An allocation of administrative/overhead costs as allowed in accordance with HIM-15, using either the step down cost allocation method (HIM-15, Chapter 2300) or the functional allocation method (HIM-15, Chapter 2100, Section 2150.3). This option will only be available for those state agencies that provide institutional and acute care services and file these costs via Medicare cost reports.

Total Allowable Costs by service by practitioner:

The allowable costs for a rehabilitative behavioral health service by practitioner will be the sum of allowable direct costs, supervisory costs as applicable, and the determination of indirect costs as determined above.

Service/Practitioner Statistics:
The State Owned and Non-State Owned governmental providers will be required to accumulate and report service utilization statistics (i.e. units of service) for the total universe of service recipients in keeping with the accumulation of costs by total population of users.

Reconciliation of Annual Cost Reports to Interim Payments:
Annual cost reports will be desk reviewed for accuracy and compliance with OMB- A87 cost definitions and principles. The result of total allowable costs (per service and practitioner) divided by total units of service (as defined above) result in the average allowable unit rate for reconciliation and cost settlement. The average allowable unit rate multiplied by Medicaid units of service (as determined by the SCDHHS MMIS) becomes annual allowable Medicaid reimbursement for the governmental provider. This amount is compared to Medicaid interim payments (including TPL) and any prior adjustments and/or recoupments for these services. Should this comparison identify an overpayment to the provider, SCDHHS will send a letter to the provider requesting repayment within 30 days. Should the comparison identify an underpayment, an adjustment is processed through the MMIS to pay the provider the difference.

Services such as medication administration and psychological training and testing reimbursed in accordance with the applicable South Carolina Medicare Physician Fee Schedule will not be subject to retrospective cost settlement.

Rehabilitative Services for Primary Care Enhancement as defined in 3.1-A, pages 6c and 6d, paragraphs 13d. A, B, C and D may be provided by a physician or other licensed practitioner of the healing arts, or under the direction of a physician or other licensed practitioner of the healing arts as permitted by 42 CFR 440.130(d). The following services will be reimbursed by Medicaid as a rehabilitative service for Primary Care Enhancement:

(A) - Individual rehabilitative services for Primary Care Enhancement provided by a professional or a paraprofessional (unit of service - 15 minutes)

(B) - Group rehabilitative services for Primary Care Enhancement provided by a professional or a paraprofessional (unit of service - 15 minutes)

(C) - Assessment provided by a professional (unit of service - 15 minutes)

Medicaid reimbursement rates for rehabilitative 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. The rates will represent composite rates, in that professional and paraprofessional costs will be combined in order to establish one rate for each service. 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 rehabilitative services for Primary Care Enhancement is defined as fifteen (15) minutes of service delivery.