6. An outlier set-aside adjustment (to cover outlier payments described in 9 and 10 of this section) will be made to the per discharge rates.

7. Payment for services provided in freestanding long-term care psychiatric facilities shall be based on the statewide average per diem for psychiatric long-term care. The base per diem rate will be the statewide total costs of these psychiatric services divided by total psychiatric days.

8. The payments determined under both payment methods, the hybrid payment system for general acute care hospitals, including acute psychiatric and rehabilitation units, and short term care psychiatric hospitals and the per diem method for psychiatric long-term care facilities, will be adjusted to recognize facility specific costs associated with direct and indirect medical education, capital and ancillary services as appropriate. In addition to the claims payment, hospitals may receive other payments as outlined in this Attachment. Some examples are as follows: Section VI J describes hospital cost settlements and Section VII describes Disproportionate Share Hospital payments.

   Effective October 1, 1999, South Carolina Department of Mental Health hospitals will be reimbursed 100% of their allowable Medicaid inpatient cost through a retrospective cost settlement process. For clarification purposes, settlements will be determined on a per patient day basis. Effective October 1, 2010, non-state owned governmental long-term care psychiatric hospitals will be reimbursed 100% of their allowable Medicaid inpatient cost through a retrospective cost settlement process.

9. Special payment provisions, as provided in Section VI A of this plan, will be available under the hybrid payment system for discharges paid by DRG which are atypical in terms of patient length of stay or costs of services provided during the stay. These cases will be referred to as outliers. Special payment policies, as specified in Section VI C and D of this plan, will also be made for cases involving a transfer of a patient from one hospital to another, or a readmission of a patient following an earlier discharge. These provisions are not applicable to long-term psychiatric and RTF claims.

10. Reduced payment, as specified in Section VI B of this plan, will be made for cases paid on a per diem basis having stays exceeding two hundred percent of the statewide geometric average length of stay.

11. A rate reconsideration process will be available to hospitals that have higher costs as a result of conditions described in IX A of this plan.

12. Disproportionate share payments will be paid to qualifying hospitals in accordance with the requirements specified in Section VII of this plan.

13. Payment for services provided in psychiatric residential treatment facilities shall be an all-inclusive per diem rate. Section II paragraph 30 of this plan defines the costs covered by the all-inclusive rate. Each facility's per diem rate will be calculated using base year data trended forward. Section V B describes the rate calculation.

14. Effective for services provided on or after July 1, 2004, qualifying hospitals with burn intensive care units will receive annual retrospective cost settlements for the total cost of inpatient services provided to South Carolina Medicaid patients.

II. Definitions Applicable to Inpatient Hospital and Residential Treatment Facility Reimbursement

The following definitions will help in understanding the payment rates set for inpatient hospital and residential treatment facility services:

1. Administrative Days - The days of service provided to recipients who no longer require acute hospital care, but are in need of nursing home placement that is not available at the time. The patient must meet either intermediate or skilled level of care criteria.

2. Arithmetic Mean (average) - The product of dividing a sum by the number of its observations.

3. Base Year - The fiscal year used for calculation of payment rates. For the hybrid payment system rates effective on and after October 1, 2010, the base year shall be each facility's 2006 fiscal year. For the freestanding long-term psychiatric hospital rates, the base year shall be each facility's 1990 fiscal year.

4. Burn Intensive Care Unit Cost Settlement Criteria - In order to qualify for this cost settlement a hospital must satisfy all of the following criteria. A hospital must:

   - Be located in South Carolina or within 25 miles of the South Carolina border;
   - Have a current contract with the South Carolina Medicaid Program; and
   - Have at least 25 beds in its burn intensive care unit.

5. Capital - Cost associated with the capital costs of the facility. Capital costs include, but are not limited to, depreciation, interest, property taxes, property insurance, and directly assigned departmental capital lease costs. In no case shall the capital amount include amounts reflecting revaluation of assets due to change of ownership or leasing arrangement subsequent to September 1, 1984.

6. Case-Mix Index - A relative measure of resource utilization at a hospital.

7. Cost - Total SC Medicaid allowable costs of inpatient services, unless otherwise specified.

8. CRNA - Certified Registered Nurse Anesthetist.

9. Diagnosis Related Groups (DRGs) - A patient classification that reflects clinically cohesive groupings of patients who consume similar amounts of hospital resources.

10. Direct Medical Education Cost - Those direct costs associated with an approved intern and resident or nursing school teaching program as defined in the Medicare Provider Reimbursement Manual, publication HIM-15.

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 October 1, 2010.

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.

B. Objectives

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

a. Payment Method

Services under this part shall be reimbursed the lesser of the charge for the service or the fixed fee. A fixed fee is assigned for each service type under this part.

II. Utilization Review

1. DHHS shall review the medical necessity of all services rendered under this part. Such review may occur on a pre-or post-payment basis or, at the options of DHHS may occur prior to the rendering of the service. Where such services are determined not medially necessary, payment shall be recovered using the most expedient means, or denied in its entirely.

2. DHHS shall also review the appropriateness of billing for all service types. Such review may occur pre- or post-payment and may produce payment denial or recovery by the most expedient means possible.

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.

Under the alternative payment methodology, reimbursement for medically necessary services will be made at 100% of the all-inclusive rate per encounter as established by the Medicare Intermediary. The Medicare rates 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.

Supplies and injections are not billable services and thus are included in the all-inclusive rate. While family planning contraceptives, the technical component of x-rays and EKGs, diagnostic laboratory services, and the application of fluoride varnish are not considered part of the all-inclusive rate, the services can be billed and reimbursed separately under the appropriate Medicaid fee schedules.

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.

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.

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 FQHCs' fiscal year will provide reimbursement at least equal to the amount available under the PPS methodology.

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. <u>Indian Health Service (IHS) Facilities:</u>

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.

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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:

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. 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 will be reimbursed at 60 percent of the Medicaid physician fee schedule rate for providing medical directed supervision of a Certified Registered Nurse Anesthetist (CRNA).

Effective July 1, 2005, pediatric sub-specialist providers will receive an enhanced Medicaid rate for evaluation & management, medical & surgical procedure codes. These enhanced rates will not exceed 120 percent of the Medicare fee schedule for certain evaluation and management codes as determined by the state agency. All other CPT codes will not exceed 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:

Reimbursement is calculated in the same manner as for Physicians' services. Refer to 5.

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 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: 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: Reimbursement for midwifery services for a normal vaginal birth are based on the lesser of billed charges, 100% of the allowed provider reimbursement for a routine delivery* or the provider's lowest charge. For services provided at a birthing center, the midwife will receive an additional payment not to exceed 50% of the statewide average rate for a normal vaginal hospital birth.

All other obstetrical services provided by midwives are reimbursed at the allowed provider reimbursement (*) based on South Carolina's Physician Fee Schedule.

* Allowed provider reimbursement is based on provider type, i.e. certified or licensed midwife. A certified midwife receives 100% of the

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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 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 (50% percentile).

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).

10. 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.

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.2. 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 419-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 web site at http://www.scdhhs.gov/ServiceProviders/FeeSchedules.asp.

The SCDHHS does not publish a fee schedule for Hospitals and Home Health services. The payment methodology for Hospital Services can be found at 4.19-B page 1a.1 and Home Health can be found at 4.19-B page 3.1.

11.c. Speech/Language and Audiological Services:

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.2. 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 419-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 web site at http://www.scdhhs.gov/ServiceProviders/FeeSchedules.asp.

The SCDHHS does not have a published fee schedule for Hospitals and Home Health services. The payment methodology for Hospital Services can be found at 4.19-B page 1a.1 and Home Health can be found at 4.19-B page 3.1.

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. 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 AWP (Average Wholesale Price) minus 10%. The AWP 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. 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:

"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 <u>Prosthetic Devices and Medical Supplies, Equipment and Services:</u>

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.

Pregnant women, individuals participating in family planning services, infants and children up to ate 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 <u>Eyeglasses</u>

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