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State/Territory Name: South Carolina

State Plan Amendment (SPA) #: 16-0005

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
61 Forsyth Street S.W. Suite 4T20
Atlanta, Georgia 30303

Atlanta Regional Operations Group

April 24, 2019

Mr. Joshua D. Baker
Director
SC Department of Health and Human Services
Post Office Box 8206
Columbia, South Carolina 29202-8206

Attention: Sheila Chavis

Re: South Carolina State Plan Amendment 16-0005

Dear Mr. Baker:

We have reviewed the proposed South Carolina State Plan Amendment, SC 16-0005, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on September 29, 2016. This amendment was submitted to establish an alternate payment methodology prospective payment system for Federally Qualified Health Centers (FQHC). This plan also describes the State's changes in scope of service reimbursement policy for South Carolina Medicaid FQHC providers.

Based on the information provided, the Medicaid State Plan Amendment SC 16-0005 was approved on April 23, 2019. The effective date of this amendment is July 1, 2016. We are enclosing the approved HCFA-179 and a copy of the new state plan pages.

If you have any additional questions or need further assistance, please contact Cheryl Wigfall at (803) 252-7299 or Cheryl.wigfall@cms.hhs.gov.

Sincerely,

/s/

Shantrina D. Roberts, MSN
Deputy Director
Division of Medicaid Field Operations-South

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: 16-0005

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
July 1, 2016

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 – Subchapter C

7. FEDERAL BUDGET IMPACT:
a. FFY 2016 $ Budget Neutral
b. FFY 2017 $ Budget Neutral

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-b pages, 1f, 1f.1 (new page), 1f.2 (new page), and 1g

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Attachment 4.19-b pages, 1f, 1g

10. SUBJECT OF AMENDMENT:
Establishment of Alternate Payment Methodology Prospective Payment Rates for FQHCs effective July 1, 2016.

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

12. SIGNATURE OF STATE AGENCY OFFICIAL:
/s/

13. TYPED NAME:
Christian L. Soura

14. TITLE:
Director

15. DATE SUBMITTED:
September 29, 2016

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: 09/29/16

18. DATE APPROVED: 04/23/19

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
07/01/16

20. SIGNATURE OF REGIONAL OFFICIAL:
/s/

21. TYPED NAME: Shantrina D. Roberts

22. TITLE: Deputy Director
Division of Medicaid Field Operations-South

23. REMARKS:

2. Under the alternative payment methodology, new RHCs will initially be reimbursed at 100% of the all-inclusive encounter rate as determined by the Medicare Regional Intermediary. Reimbursement is subject to annual revision to the actual cost rate as determined by the Medicare Intermediary based on the RHC's fiscal year. In the event that a new RHC 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 RHCs in the same or an adjacent area with a similar caseload.

3. For those RHCs 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 RHC does not receive less reimbursement than would be received under the cost based or PPS reimbursement methodologies. A final annual reconciliation of quarterly supplemental payments will be included in the RHC's fiscal year cost settlement and rate determination.

2c. Federally Qualified Health Centers:

Baseline PPS Rate Setting Methodology

For FQHCs not agreeing to the APM PPS 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.

Alternative Payment Methodology (APM) PPS Rate Setting Methodology

Effective for services provided on and after July 1, 2016, the Medicaid Agency will provide reimbursement to Federally Qualified Health Centers (FQHCs) using an alternate payment methodology (APM) via a prospective payment system (PPS). FQHCs must agree to the APM in order to receive payment in accordance with the APM PPS rate setting methodology. The APM PPS will provide reimbursement to FQHCs which will be at least equal to the amount that would be received using the Benefits Improvement and Protection Act of 2000 (BIPA 2000) baseline PPS methodology trended by the MEI annually. The Fiscal Year (FY) 2001 baseline PPS rates were determined by weighing the FQHC provider specific rates for provider FYs 1999 and 2000 based on reasonable cost principles, by the number of Medicaid encounters provided in each year. The APM PPS methodology employed by the Medicaid Agency effective for services provided on and after July 1, 2016 is described below.

First, for each South Carolina FQHC not deemed as a low volume FQHC provider, the fiscal year ending 2014 desk audited Medicaid rate is determined in accordance with the APM in effect prior to July 1, 2016. Under the former APM payment methodology, the cost reports, as submitted, are reviewed for accuracy, reasonableness and allowability of costs as defined per 45 CFR section 75 - Uniform Administrative Requirements, Cost Principles, and Audit Requirements as well as 42 CFR section 413 - Principles of Reasonable Cost Reimbursement. While direct costs of providing SC Medicaid covered FQHC services will be recognized at 100%, overhead costs are limited to no more than 30%. Additionally, the following minimum productivity levels were employed in order to determine the FY 2014 FQHC Medicaid payment rates - physicians shall be 4,200 patient visits per year; mid-level practitioners shall be 2,100 patient

visits per year; and OB/GYN physicians shall be 3,360 patient visits per year. Next, in order to trend the FY 2014 APM PPS rates to the prospective payment period beginning July 1, 2016, the Medicaid Agency employed the use of the midpoint to midpoint trending methodology using the IHS Global Insight 2015 Quarter 3 Forecast published December 22, 2015. For out of state border FQHCs that contract with the State Medicaid Agency or for those in-state FQHCs deemed as a low volume FQHC (i.e. provides less than 50 SC Medicaid FFS encounters during its FY 2014 reporting period), their APM PPS rate effective July 1, 2016 will be based upon its rate in effect on June 30, 2016 increased by 5.48% trend. For out of state border FQHCs that contract with the SC Medicaid Agency for the first time on or after July 1, 2016, the SC Medicaid Agency will reimburse the FQHC at the Medicaid rate in effect upon entrance into the SC Medicaid program as determined by its state's Medicaid Agency. Future Medicaid rates will be adjusted accordingly.

For those FQHCs that are not Public Health Service (PHS) grantees but are designated as "look alikes", these entities have the choice of being reimbursed under the APM PPS or baseline PPS methodology as described under section 2c of Attachment 4.19-B.

Scope of Service Changes

The baseline PPS rate or the APM PPS rate will be adjusted to take into account any change (increase or decrease) in the scope of services furnished by the FQHC. A change in the cost of a service is not considered in and of itself a change in the scope of services. A change in scope will be defined as:

- A change in the type, intensity, duration, and/or amount of services or;
- Adding a South Carolina Medicaid service that was not included in the baseline PPS rate or APM PPS rate calculation or;
- Deleting a South Carolina Medicaid service that was included in the baseline PPS rate or APM PPS rate calculation or;
- Incurring a minimum five percent (5%) cost increase in overhead costs or direct medical costs as a result of the acquisition of or implementation of a singular project or equipment purchase that is not covered by any of the other scope of service change criteria.

The FQHC will be responsible for notifying the Division of Ancillary Reimbursements, in writing, of any increases or decreases in the scope of its services. A modified rate will be established based upon the allowable Medicaid reimbursable costs subject to the reasonableness definitions as described earlier and contained in the annual budget information and effective for services provided on and after the implementation of the scope of service change.

Circumstances Requiring Special Consideration/Disposition:

1. Under the APM PPS 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 based upon the APM payment methodology in effect prior to July 1, 2016. Reimbursement will be reconciled to actual cost on an annual basis based on the FQHC's fiscal year for a minimum period of two years before establishing the annual July 1st APM PPS rate. 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.

2. For those FQHCs participating as a member of Medicaid Managed Care Organizations (MCOs) and receiving either APM PPS cost based or baseline PPS reimbursement, the Medicaid Agency will ensure that Medicaid MCOs, at a minimum, are reimbursing FQHCs at least 100% of the July 1, 2016 APM PPS rates on a quarterly basis. However supplemental payments will be made to the FQHCs by the Medicaid Agency only under the following conditions:

    - Dental encounters, a service not provided by SC Medicaid MCOs, will be reconciled quarterly to ensure that the FQHC will receive the Medicaid FFS payment rate for the services provided to MCO members. This process will also hold true for Medicaid fee for service (FFS) individuals receiving dental services provided by a FQHC.

    - For provider rate changes that have not been reflected in the calculation of the annual SC Medicaid MCO rates due to: (1) new FQHCs coming into the Medicaid Program under budget rates; (2) any scope of service rate changes to APM PPS rates since their base year FY 2014 cost report;(3) for FQHC providers operating under the baseline PPS rates with scope of service changes not reflected in their current baseline PPS rate and;(4) if a rate adjustment is required for any other reason than described above. In these instances, payment adjustments will be made to include encounters (FFS and MCO) until that point in time in which the revised rate of the impacted FQHC is reflected in the Medicaid MCO rates.

While quarterly WRAP payments will be made subject to the circumstances outlined within each bullet above within thirty days of receipt of the quarterly Medicaid MCO encounter data submitted from the contracting Medicaid MCOs, annual WRAP reconciliations will be performed and adjustments processed (if applicable) within sixty days after the receipt of the annual Medicaid MCO encounter data from the Medicaid MCOs. Medicaid MCOs will be required to submit the quarterly and annual FQHC encounter data within sixty days from the end of the quarter or annual period requested.

2e. Indian Health Service (IHS) Facilities:

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