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State/Territory Name: South Carolina

State Plan Amendment (SPA) #: 12-020

This file contains the following documents in the order listed:

1) RO Follow-Up Approval Letter
2) Pharmacy Approval Letter
3) CMS 179 Form
4) Approved SPA Pages

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

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

February 8, 2013

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 #12-020

Dear Mr. Keck:

This is to affirm approval of the above referenced State Plan Amendment which was submitted to the Regional Office on December 28, 2012. The State's requested effective date of January 1, 2013 has been accepted.

Enclosed for your records are:

1. a copy of the approval letter dated February 7, 2013 that was submitted to the State by Larry Reed, Director, Division of Pharmacy;

2. the original signed 179; and

3. the approved plan page.

If you have any additional questions regarding this amendment, please contact Maria Drake, State Coordinator for South Carolina, at 404-562-3697.

Sincerely,

//s//

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

Enclosures

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-14-26
Baltimore, Maryland 21244-1850

Disabled & Elderly Health Programs Group

February 7, 2013

Anthony E. Keck
Director
South Carolina Department of Health and Human Services
P.O. Box 8206
Columbia, South Carolina 29202-8206

Dear Mr. Keck:

We have reviewed South Carolina State Plan Amendment (SPA) 12-020 received in the Atlanta Regional Office on December 28, 2012. Under this SPA, the state proposes changes in pharmacy coverage as required by Section 175 of the Medicare Improvement for Patients and Providers Act of 2008 which amended section 1860D-2(e)(2)(A) of the Act to include barbiturates "used in the treatment of epilepsy, cancer, or a chronic mental health disorder" and benzodiazepines in Part D drug coverage effective as of January 1, 2013.

We are pleased to inform you that South Carolina SPA 12-020 is approved, effective January 1, 2013. The Atlanta Regional Office will forward to you a copy of the CMS-179 form, as well as the pages approved for incorporation into the South Carolina Medicaid State Plan. If you have any questions regarding this amendment, please contact Bernadette Leeds at (410) 786-9463.

Sincerely,

/s/

Larry Reed
Director
Division of Pharmacy

cc: Jackie Glaze, ARA, Atlanta Regional Office
Maria Drake, Atlanta Regional Office
Elizabeth Hutto, South Carolina Department of Health and Human Services
Valeria Williams, South Carolina Department of Health and Human Services

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 12-020

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
January 1, 2013

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:
Section 1935 (d)(2) of the Social Security Act
(2) COVERAGE OF CERTAIN EXCLUDABLE DRUGS

7. FEDERAL BUDGET IMPACT:
a. FFY 2012 **($ 399,006)**
b. FFY 2013 **($ 585,209)**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 3.1.A.1, page 3

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 3.1.A.1, page 3

10. SUBJECT OF AMENDMENT:
Effective January 1, 2013, to exclude Medicaid coverage of barbiturates used in the treatment of epilepsy, cancer, or a chronic mental health disorder and benzodiazepines for full-benefit dual eligible individuals who will be entitled to receive Medicare benefits under Medicare Part D drug coverage plans at that time.

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:
//s//

13. TYPED NAME: Anthony E. Keck

14. TITLE:
Director

15. DATE SUBMITTED: 12-20-12

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:
12-28-12

18. DATE APPROVED: 02-07-13

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
01/01/13

20. SIGNATURE OF REGIONAL OFFICIAL:
//s//

21. TYPED NAME:
Jackie Glaze

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

23. REMARKS:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Agency _South Carolina Department of Health and Human Services_____

MEDICAID PROGRAM: REQUIREMENTS RELATING TO PAYMENT FOR COVERED OUTPATIENT DRUGS FOR THE CATEGORICALLY NEEDY

Citation (s)		Provision (s)
1927(d)(2) and 1935(d)(2)	☐	(g) covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee (see specific drug categories below)
	☒	(h) barbiturates (see specific drug categories below) (Except for dual eligible individuals effective January 1,2013 when used in the treatment of epilepsy, cancer or a chronic mental health disorder as Part D will cover those indications)
	☒	(i) benzodiazepines (see specific drug categories below) (Except for dual eligible individuals effective January 1, 2013 as Part D will cover all indications)
	☒	(j) smoking cessation, except dual eligibles as Part D will cover (see specific drug categories below)

(The Medicaid agency lists specific category of drugs below)

(a) South Carolina Medicaid will only cover lipase inhibitors

(e) All categories of rebateable vitamins and mineral products, including prenatal vitamins and fluoride

(f) Over the counter (OTC) drugs that are in the Medicaid drug rebate program and correspond to the covered legend drugs in (e) and (j)

(h) All categories of rebateable barbiturates.

(i) All categories of rebateable benzodiazepines.

(j) All categories of rebateable smoking cessation products

__ **No excluded drugs are covered.**

State Plan Under Title XIX of the Social Security Act
Medical Assistance Program
State: NORTH CAROLINA

Payments for Medical and Remedial Care and Services: Inpatient Hospital

EXCEPTIONS TO DRG REIMBURSEMENT

(a) Covered psychiatric and rehabilitation inpatient services provided in either specialty hospitals, Medicare recognized Long Term Acute Care Hospitals (LTCH), Medicare recognized distinct part units (DPU), or other beds in general acute care hospitals shall be reimbursed on a per diem methodology.

(1) Prior to October 1, 2008, psychiatric inpatient services are defined as admissions where the primary reason for admission would result in the assignment of a psychiatric DRG code in the range 424 through 437 and 521 through 523. Effective October 1, 2008, the assignment of a psychiatric DRG code is in the range 880 through 887 or 894 through 897 or 876. All services provided by specialty psychiatric hospitals are presumed to come under this definition.

Prior to October 1, 2008, rehabilitation inpatient services are defined as admissions where the primary reason for admissions would result in the assignment of DRG 462. Effective October 1, 2008, the assignment of a rehabilitation DRG code is 945 or 946. All services provided by specialty rehabilitation hospitals and Medicare recognized Long Term Acute Care Hospitals (LTCH) are presumed to come under this definition.

(2) When a patient has a medically appropriate transfer from a medical or surgical bed to psychiatric or rehabilitative distinct part unit within the same hospital or to a specialty hospital the admission to the distinct part unit or the specialty hospital shall be recognized as a separate service which is eligible for reimbursement under the per diem methodology.

Transfers occurring within general hospitals from acute care services to non-DPU psychiatric or rehabilitation services are not eligible for reimbursement under this Section. The entire hospital stay in these instances shall be reimbursed under the DRG methodology.

(3) The per diem base rate for psychiatric services is established at the lesser of the actual cost or the calculated median rate of all hospitals providing psychiatric services, as derived from the 2003 Medicaid cost report or the most recent as filed cost report, trended forward to the rate year. Providers that routinely provide psychiatric services and whose base rate trended forward to State Fiscal Year 2005 is less than their rate as of October 1, 2004, shall have their base rate established at the October 1, 2004 amount and trended forward in subsequent years.

(4) Hospitals that do not routinely provide psychiatric services shall have their rate set at the median rate for all other psychiatric hospitals in paragraph (3) above.

State Plan Under Title XIX of the Social Security Act
Medical Assistance Program
State: NORTH CAROLINA

Payments for Medical and Remedial Care and Services: Inpatient Hospital

(5) The per diem rate for rehabilitation services is established at the lesser of the actual cost trended to the rate year or the calculated median rate of all hospitals providing rehabilitation services as derived from the most recent filed cost reports.

(6) Rates established under this Paragraph are adjusted for inflation consistent with the methodology under Subparagraph (d)(5) of the DRG RATE SETTING METHODOLOGY.

(7) Rates established under this Paragraph shall be prospectively determined and shall not be subject to retrospective settlement.

(b) Hospitals operated by the Department of Health and Human Services, all the primary affiliated teaching hospitals for the University of North Carolina Medical Schools will be reimbursed their reasonable costs in accordance with the provisions of the Medicare Provider Reimbursement Manual. Critical Access Hospital pursuant to 42 USC 1395i-4 will be reimbursed their reasonable costs for acute care services in accordance with the provision of the Medicare Provider Reimbursement Manual. This Manual referred to as (CMS Publication #15-1) is hereby incorporated by reference including any subsequent amendments and editions. Interim payment rates will be estimated by the hospital and provided to the Division of Medical Assistance (DMA) subject to DMA review. These rates will be set at a unit value that can best be expected to approximate 100% of reasonable cost. Interim payments made under the DRG methodology to these providers shall be retrospectively settled to reasonable cost.

(c) Hospitals operating Medicare approved graduate medical education programs shall receive a per diem rate adjustment which reflects the reasonable direct and indirect costs of operating these programs. The per diem rate adjustment will be calculated in accordance with the provisions of DRG Rate Setting Methodology.

State Plan Under Title XIX of the Social Security Act
Medical Assistance Program
State: NORTH CAROLINA

Payments for Medical and Remedial Care and Services: Inpatient Hospital

(d) The Division of Medical Assistance shall establish a unit value for each hospital which represents the DRG payment rate for a DRG with a relative weight of one. This rate is established as follows:

(1) Using the methodology described in Paragraph (c) of this plan, the Division shall estimate the cost less direct and indirect medical education expense on claims for discharges occurring during calendar year 1993, using cost reports for hospital fiscal years ending during that period or the most recent cost report available. All cost estimates are adjusted to a common 1994 fiscal year and inflated to the 1995 rate year.

The average cost per discharge for each provider is calculated. (See Exhibit page 25 of the plan). The state reserves the right to rebase based upon a year selected by the state.

(2) Using the DRG weights to be effective on January 1, 1995, a CMI is calculated for each hospital for the same population of claims used to develop the cost per discharge amount in Subparagraph (d)(1) of this plan. Each hospital's average cost per discharge is divided by its CMI to get the cost per discharge for a service with a DRG weight of one.

(3) The amount calculated in Subparagraph (d)(2) of this plan is reduced by 7.2% to account for outlier payments.

(4) Hospitals are ranked in order of increasing CMI adjusted cost per discharge. The DRG Unit Value for hospitals at or below the 45th percentile in this ranking is set using 75% of the hospital's own adjusted cost per discharge and 25% of the cost per discharge of the hospital at the 45th percentile. The DRG Unit Value for hospitals ranked above the 45th percentile is set at the cost per discharge of the 45th percentile hospital. The DRG unit value for new hospitals and hospitals that did not have a Medicaid discharge in the base year is set at the cost per discharge of the 45th percentile hospital. New hospitals inpatient rates will subsequently be established based on one year's cost report and implemented on the October 1 of next year. Existing hospitals that enter into a Change of Ownerships (CHOW) shall have the hospital's rates established based on the previous hospital's rates. Critical Access Hospitals' (CAH) rates will be established based on the same hospital's Acute Care Hospital rates. Effective each October 1, Critical Access Hospitals (CAH) interim rates will be established at 90% of the last audited CAH cost report completed as of June 1. The actual reimbursement amount for a DRG billing is the product of the hospital specific rate times the relative weight and unit value for that DRG exclusive of add-ons (i.e. DSH and outliers).

(5) The hospital unit values calculated in Subparagraph (d)(4) of this plan shall be updated annually by the National Hospital Market Basket Index as published by Medicare and applied to the most recent actual and projected cost data available from the North Carolina Office of State Budget, Planning, and Management. This annual update shall not exceed the update amount approved by the North Carolina General Assembly. Effective October 1, 1997, for fiscal year ended September 30, 1998 only the hospital unit values calculated in Subparagraph (d)(4) of this plan shall be updated by the lower of the National Hospital Market Basket Index as published by Medicare and applied to the most recent actual and projected cost data available from the North Carolina Office of State Budget, Planning, and Management or the Medicare approved Inpatient Prospective Payment update factor. Notwithstanding any other provision, if specified, these rates will be adjusted as shown on Attachment 4.19-A, Supplement 1, Page 3 of the Sate Plan.

(6) Allowable and reasonable costs will be reimbursed in accordance with the provisions of the Medicare Provider Reimbursement Manual referred to as CMS Publication 15-1.

State Plan Under Title XIX of the Social Security Act
Medical Assistance Program
State: NORTH CAROLINA

Payments for Medical and Remedial Care and Services: Inpatient Hospital

DRG RATE SETTING METHODOLOGY

(a) Diagnosis Related Groups is a system of classification for hospital inpatient services. For each hospital admission, a single DRG category shall be assigned based on the patient's diagnosis, age, procedures performed, length of stay, and discharge status. For claims with dates of services prior to January 1, 1995 payments shall be based on the reimbursement per diem in effect prior to January 1, 1995. However, for claims related to services where the admission was prior to January 1, 1995 and the discharge was after December 31, 1994, then the greater of the total per diem for services rendered prior to January 1, 1995, or the appropriate DRG payment shall be made.

(b) The Division of Medical Assistance (Division) shall use the DRG assignment logic of the Medicare Grouper to assign individual claims to a DRG category. Medicare revises the Grouper each year in October. The Division shall install the most recent version of the Medicare Grouper implemented by Medicare to be effective October 1 of each following rate year. Effective October 1, 2012, the Division shall install the most recent version of the Medicare Grouper implemented by Medicare to be effective October 1 of each rate year. The initial DRG in Version 12 of the Medicare Grouper, related to the care of premature neonates and other newborns numbered 385 through 391, shall be replaced with the following classifications:

385 Neonate, died or transferred, length of stay less than 3 days
801 Birth weight less than 1,000 grams
802 Birthweight 1,000 – 1,499 grams
803 Birthweight 1,500 – 1,999 grams
804 Birthweight >=2,000 grams, with Respiratory Distress Syndrome
805 Birthweight >=2,000 grams premature with major problems
810 Neonate with low birthweight diagnosis, age greater than 28 days at admission
389 Birthweight >= 2,000 grams, full term with major problems
390 Birthweight >= 2,000 grams, full term with other problems or premature without major problems
391 Birthweight >= 2,000 grams, full term without complicating diagnoses

Effective October 1, 2008, the premature neonates and other newborn DRGs listed above are replaced by the premature neonates and other newborn DRGs in Version 25 of the Medicare Grouper (i.e. DRGs 789-795).

DRG 789 Neonate, died or transferred, length of stay less than 3 days.