



DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES
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May 20, 2011

Re: South Dakota Medicaid State Plan Amendment

Enclosed are a summary and the State Plan Amendment (SPA) documents the Department of Social Services intends to submit to the Centers for Medicare and Medicaid Services (CMS) to make the appropriate changes to the Medicaid State Plan to implement reimbursement reductions as directed by legislative appropriations.

We intend to make this SPA effective July 1, 2011. The attached documents are also available online at <http://dss.sd.gov/tribalconsultation/index.asp>

Please contact Mark Zickrick at the above address within 30 days if you have any questions or concerns.

Sincerely,

A handwritten signature in black ink, appearing to read 'Larry Iversen', written over a horizontal line.

Larry Iversen
Medicaid Director

Cc: Kim Malsam-Rysdon, DSS Secretary
Lynne Valenti, DSS Deputy Secretary
Mark Zickrick, Program Manager

Medicaid State Plan Amendment Proposal

Transmittal Number: 11-3
Effective Date: July 1, 2011

Brief Description: This State Plan Amendment implements budget reductions enacted by the 2011 Legislature and changes reimbursement methodology for certain surgical procedures involving implantable devices.

Area of State Plan Affected: The proposed changes in this Medicaid State Plan Amendment (SPA) are necessary to implement reductions in legislative appropriations and impact reimbursement in the following areas.

- Inpatient and outpatient hospitals not classified as access critical and at-risk, inpatient psychiatric units, inpatient neonatal intensive care units, rehabilitation units, rehabilitation hospitals, psychiatric hospitals, specialized surgical hospitals, and hospitals located out-of-state will have their reimbursement rates reduced by 11.48%;
- Children's care hospitals and psychiatric residential treatment facilities will have their reimbursement rates reduced by 4.5%;
- Primary care physicians, including primary care pediatricians, internal medicine, obstetrics, family practice, general practice, physician assistants, nurse practitioners, clinical nurse specialists, and doctors of osteopathy will have their reimbursement effective reduced by 4.5%. All other physician specialties will have their reimbursement rates reduced by 5.1%;
- Reimbursement of prescription drugs will be reduced by an increase in the discount from the Average Wholesale Price (AWP) of 13% to 15% and by decreasing the dispensing fee from \$4.75 to \$4.30;
- Clinic services, **excluding federally qualified health centers, rural health clinics, and Indian Health Services**, will have their reimbursement rates reduced by 5.1%;
- Reimbursement rates for dental services, dentures, orthodontic services, nutrition items and prosthetic devices will be reduced by 6.4%;
- Inpatient hospital surgically implanted device reimbursement with aggregate charges in excess of \$5,000 on cost outlier claims will change by requiring the supplier cost invoice to be submitted with the claims, with reimbursement to be calculated at cost plus 10%. The charges for the implantable device will be removed from calculation of the inpatient hospital claim.

Page(s) of State Plan Affected: Attachment 4.19-A, pages 1, 2, 3, 5, and 9; Attachment 4.19-B, pages 1b, 4, 6, 15, 16, 20, 21, and 22.

Estimate of Fiscal Impact, if Any: \$4,577,636 for Federal Fiscal Year 2011 and \$13,732,909 for Federal Fiscal Year 2012.

Reason for Amendment: The 2011 Legislature, in enacting a budget for State Fiscal Year 2012, reduced funding for all State agencies. Many programs in the Department of Social Services were impacted, including Medicaid. This SPA implements the necessary changes to the State Plan payment methodologies to comply with the appropriated budget according to House Bill 1251 and the Joint Committee on Appropriations' Letter of Intent.

INPATIENT HOSPITAL PAYMENT METHODOLOGY

GENERAL

The South Dakota Medicaid program has been reimbursing hospitals for inpatient services, with a few exceptions, under a prospective Diagnosis Related Group (DRG) methodology since January 1, 1985. South Dakota uses the federal definitions of DRGs, DRG classifications, weights, geometric mean lengths of stay, and outlier cutoffs as used for the Medicare prospective payment system. The DRG grouper program is updated annually as of October 1 of each year, beginning with the Medicare grouper version 15 (effective October 1, 1997). The State agency calculates Medicaid Program specific weight and geometric mean length of stay factors annually using the latest three years of non-outlier claim data, this three year claim database updated annually in order to establish new weight and geometric length of stay factors with each new grouper.

The agency developed hospital specific costs per Medicaid discharge amounts for all in-state hospitals using Medicare cost reports and non-outlier claim data for the hospitals' fiscal years ending after June 30, 1996 and before July 1, 1997. The agency applied an inflation factor, specific to each hospital's fiscal year end, to the cost per discharge amounts of all hospitals with more than thirty (30) Medicaid discharges during the base year to establish target amounts for the period of October 1, 2010 through September 30, 2011. There is a cap on the hospitals' target amounts, under which no hospital is allowed a target amount that exceeds 110% of the statewide weighted average of all target amounts.

South Dakota Medicaid reimburses out-of-state hospitals on the same basis as the hospital is paid by the Medicaid agency in the state in which the hospital is located. If the hospital's home state refuses to provide the amount they would pay for a given claim, the payment will be at 50% of billed charges. Payment will be for individual discharge or transfer claims only; there will be no annual cost settlement with out-of-state hospitals or with in-state DRG hospitals unless an amount is due the South Dakota Medicaid program.

For claims with dates of service from July 1, 2011 through June 30, 2012, the amount of reimbursement for in-state DRG hospitals and all out-of-state hospitals, will be reduced by 11.48 percent after any cost sharing amount due from the patient, any third party liability amounts have been deducted, and other computation of any cost outlier payment. This does not apply to South Dakota hospitals that are determined by the Department of Health to be above average access-critical or above average at-risk.

SPECIFIC DESCRIPTION

The agency calculates a hospital's target amounts for non-outlier claims by dividing the hospital's average cost per discharge for non-outlier claims by the hospital's case mix index. To ensure budget neutrality, the agency adjusts annually a hospital's target amount for any change in that hospital's case mix index resulting from the establishment of new program specific weight factors. For each hospital, the case mix index is the calculated result of accumulating the weight factors for all claims submitted during the base period and dividing by the number of claims.

The average cost per discharge for non-outlier claims was calculated by subtracting the charges for ancillary services on outlier claims, multiplied by the average ancillary cost to charge ratio, from the total allowable ancillary charges for the hospital. Total Medicaid days and discharges were reduced by the number of days and discharges from outlier claims to calculate the routine costs for non-outlier claims. Routine costs and ancillary costs related to non-outlier claims were added and then the total allowable costs were divided by the number of non-outlier discharges during the base period.

CAPITAL COSTS

Interim payments for capital and education costs will be made to instate hospitals that had more than thirty (30) Medicaid discharges during the hospitals' fiscal year ending after June 30, 1996 and before July 1, 1997 on a per diem basis. The agency will calculate hospital-specific interim rates using the most recently reviewed Medicare cost report, with reimbursements being reduced 11.48% for the year beginning July 1, 2011, and ending June 30, 2012. This does not apply to South Dakota hospitals that are determined by the Department of Health to be above average access-critical or above average at-risk, or for hospitals designated as Critical Access by Medicare.

TRANSFER PATIENTS

Payment will be allowed to the transferring hospital whenever a patient is transferred to another hospital regardless of whether the receiving hospital is paid under the DRG system or is an exempt hospital or unit.

The amount of payment made to the transferring hospital will be on a per diem basis. The per diem rate will be calculated by dividing the standard DRG payment for the particular stay by the geometric mean length of stay for the DRG. The per diem rate will then be multiplied by the number of days stay prior to the transfer. In no instance will the payment to the transferring hospital be any higher than the full DRG payment amount if the patient had been discharged home. The daily capital/education pass-through will be added to the DRG payment.

The receiving hospital will be paid a normal DRG payment unless the patient is again transferred to another hospital.

COVERED DIAGNOSTIC RELATED GROUPS

South Dakota will adopt all DRGs, except DRG 522, established in the version of the grouper program being used by the Department as of the admission date on the claim.

SERVICES COVERED BY DIAGNOSTIC RELATED GROUP PAYMENTS

The Department will adopt Medicare's definition of inpatient hospital services covered by DRG payment. As a result, providers must submit claims for reimbursement for physician services on a separate CMS 1500 form.

OUTLIER PAYMENTS

The Department will make additional payments to hospitals for discharges which meet the criteria of an "outlier." An outlier is a case with extremely high charges which exceed cost outlier thresholds.

A claim will qualify for a cost outlier payment when 70% of billed charges exceed the larger of \$58,829 or 1.5 times the DRG payment for the claim. The additional payment allowed for a cost outlier will be 90% of the difference between 70% of billed charges and the larger of \$58,829 or 1.5 times the DRG payment.

The total payment allowed for an outlier claim will be the DRG payment plus the outlier payment plus the daily capital/education amount for each day of the hospital stay.

SURGICALLY-IMPLANTED DEVICES AND APPLIANCES

The Medicaid program will reimburse claims submitted for inpatient hospital services by an in-state acute care hospital that had more than 30 Medicaid discharges during the hospital's fiscal year ending after June 30, 1996, and before July 1, 1997, that are considered to be cost outlier claims as defined by ARSD 67:16:03:01(3) and contain revenue codes 275 or 278 according to the following guidelines:

1. Reimbursement for aggregate charges in excess of \$5,000 associated with revenue codes 275 or 278 will be limited to the provider's actual cost plus 10%; and
2. Aggregate charges for revenue codes 275 or 278 in excess of \$5,000 will be removed from the calculation of the claim and charges associated with the remainder of the claim will be reimbursed according to ARSD 67:16:03:06.

The provider must provide the Department with copies of the suppliers' invoices for items associated with revenue codes 275 and 278.

5. Rehabilitation Units (only upon request and justification);
6. Children's Care Hospitals;
7. Indian Health Service Hospitals;
8. Hospitals with less than 30 Medicaid discharges during the hospital's fiscal year ending after June 30, 1993, and before July 1, 1994; and
9. Specialized Surgical Hospitals.

Payment for the above instate exempt facilities and/or units, except for psychiatric hospitals, psychiatric units, Indian Health Service Hospitals, specialized surgical hospitals, and instate hospitals with less than 30 Medicaid discharges during the hospital's fiscal year ending after June 30, 1993, and before July 1, 1994, will continue on the Medicare retrospective cost base system with the following exceptions:

1. Costs associated with certified registered nurse anesthetist services that relate to exempt hospitals and units will be included as allowable costs.
2. Malpractice insurance premiums attributable to exempt units or hospitals will be allowed using a 7.5% of the risk portion the premium multiplied by the ratio of inpatient charges to total Medicaid inpatient charges for these hospitals or units.

Psychiatric hospitals, psychiatric units, rehabilitation hospitals, rehabilitation units, perinatal units, and children's care hospitals will be paid on a per diem basis based on the facility's reported, allowable costs, as established by the State. This per diem amount will be updated annually as directed by legislature based on review of economic indices and input from interested parties not to exceed the rate as established by the medical care component of the Consumer Price Index of the most recent calendar year.

Specialized Surgical Hospitals will be reimbursed on a per diem basis equal to twice the per diem rate allowable for swing-bed hospitals as established in Attachment 4.19-D – Other, Provision 10.

Indian Health Service hospitals will be paid on a per diem basis as established by CMS.

Instate hospitals with less than 30 discharges during the hospital's fiscal year ending after June 30, 1993, and before July 1, 1994, will be paid 95% of billed charges.

For claims with dates of service from July 1, 2011, through June 30, 2012, the amount of reimbursement for psychiatric hospitals, rehabilitation hospitals, perinatal units, psychiatric units, rehabilitation units, and specialized surgical hospitals will be reduced 11.48 percent, and payments for children's care hospitals will be reduced by 4.5%, after any cost sharing amount due from the patient, any third party liability amounts have been deducted, and other computation of any cost outlier payment.

EXCEPTION TO PAYMENT METHODOLOGIES FOR ACCESS-CRITICAL AND AT-RISK HOSPITALS

Hospitals that have been determined by the Department of Health to be above average access-critical and above average at-risk will be reimbursed at the greater of actual allowable cost or the payment received under the provisions contained in this Attachment.

UPPER LIMITS

The State has in place a public process which complies with the requirements of Section 1902 (a) (13) (A) of the Social Security Act.

Psychiatric Residential Treatment Facilities

The Department will pay facilities based on a per diem rate prospectively calculated based upon the State fiscal year. The Department will use the same methodology for governmental and private facilities.

Providers must submit a cost report on forms designated by the Department identifying allowable costs incurred during the fiscal year. The Department will calculate rates for the facilities based upon each facility's actual allowable costs. Allowable costs include those costs that are ordinary, necessary, reasonable, and adequate to meet costs incurred by those facilities that are related to resident care services in conformance with State and Federal laws and regulations. Allowable cost centers include salaries and benefits for facilities' personnel, payroll taxes, professional fees and contract services, travel/transportation, supplies, occupancy, equipment, depreciation, and other. Non-allowable costs include bad debt, advertising, public relations, and costs not incurred by the facility including the value of donated goods and services.

Providers must maintain a daily census report that identifies the number of residents that received services on any particular day. The Department divides allowable and reasonable costs by the census data to calculate the payment rate for the next rate setting period. The census data for a resident is limited to those days in which the resident is actually present in the facility, and is subject to audit by the Department to verify its accuracy in conjunction with the submitted cost report.

Each facility must submit an annual Department-approved cost report by September 30 of each year identifying actual, previous State fiscal year historical costs. All cost reports are subject to desk review by the Department. If audit adjustments are made, the facility is notified immediately either by telephone, in writing, or electronic mail. The Department will establish desk audit rates for each facility based on the cost report desk review.

The Department calculates the final rate using a minimum occupancy limit of 90% so facilities with occupancy less than 90% will receive per diem rates based upon 90% occupancy. The rate calculated is considered payment in full for all allowable services delivered by the provider to eligible Medicaid recipients.

The Department will pay out-of-state facilities based upon the rate for comparable services established by the Medicaid agency in the state where the facility is located. If no rate is established by the Medicaid agency in that state, then the per diem rate payable to the out-of-state facility will be the lower of billed charges or the average of the per diem rates in effect for in-state facilities at the time the services are first provided by the out-of-state facility, except that a per diem rate higher than the average per diem rate may be negotiated by the Department for extraordinary or unusual circumstances on a case-by-case basis. Negotiated per diem rates may not exceed the cost of the services provided by the facility.

ATTACHMENT 4.19-B
PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

4. The agency will make interim payments to outpatient hospitals based upon Medicare principles and the above exceptions using the CMS 2552 Report, Worksheet C, Par 1 lines 37-68 as submitted by the hospitals to determine the Medicare outpatient cost-to-charge ratios (CCRs) for the ancillary cost centers for each hospital. The agency applies the hospital-specific CCRs to claims detail from the agency's MMIS pertaining to the Medicaid outpatient hospital charges associated with claims from each provider for the same dates of services as reported on the Medicare cost reports to calculate Medicaid limits per cost center. The agency uses the lesser of Medicaid costs or charges and subtracts from that amount any third party resource payments to arrive at the net Medicaid amount for each hospital and compares that amount to the total of interim payments to the hospital. Once the agency has calculated the difference between interim payments to the hospitals and the net Medicaid costs, only the calculations showing cost settlement amounts that are owed to the South Dakota Medicaid program will result in retroactive cost adjustments, those amounts being due the agency. All participating hospitals must submit their Medicare cost report to the agency within 150 days following the end of their fiscal year.

The remaining in-state hospitals will be reimbursed at 90% of billed charges. Hospitals' charges shall be uniform for all payers and may not exceed the usual and customary charges to private pay patients.

The agency will reimburse out-of-state hospitals on a prospective basis at a percentage rate equal to the average interim payment made to in-state DRG outpatient hospitals. The average interim percentage payment is based on the rates in effect at the time services are provided.

For claims with dates of service from July 1, 2011 through June 30, 2012, the amount of reimbursement for in-state DRG hospitals and all out-of-state hospitals, will be reduced by 11.48 percent after any cost sharing amount due from the patient and any third party liability amounts have been deducted. This does not apply to South Dakota hospitals that are determined by the Department of Health to be above average access-critical or above average at-risk.

TN No. 11-
SUPERCEDES
TN No. 10-7

Approval Date _____

Effective Date 7/01/11

ATTACHMENT 4.19-B
PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

4b. Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

1. Nutrition items. Payment for medically necessary items is based on a fee schedule developed by the State agency. The agency's rates were set as of July 1, 2011, and are effective for services on or after that date. The agency-developed fee schedule is based upon review of the most recent year's paid claims information, national coding lists, and documentation submitted by providers and associated medical professional organizations. All governmental and private providers will be reimbursed according to the same fee schedule published on the agency's website.
2. Orthodontic services. The agency's rates were set as of July 1, 2011, and are effective for services on or after that date. The agency-developed fee schedule is based upon review of the most recent year's paid claims information, national coding lists, and documentation submitted by providers and associated medical professional organizations. The fee schedule is published on the agency's website. Except as otherwise noted in the plan, the agency-developed fee schedule rates are the same for all governmental and private providers.

Payments for orthodontia are made in installments as follows: first payment of one third of the total allowance is made at the time of the installation of the hardware; the second payment is one third of the total allowance and made after 12 months of treatment and the provider has verified the patient is in active treatment; and the final one third of the total allowance is paid following notification from the provider that full treatment has been rendered.

3. Private duty nursing. Payment for extended nursing services is at an hourly rate based on a fee schedule developed by the State agency. The agency's rates were set as of July 1, 2006, and are effective for services on or after that date. The agency-developed fee schedule is based upon a review of the most recent year's paid claims information, national coding lists, and documentation submitted by providers and associated medical professional organizations. All governmental and private providers will be reimbursed according to the same fee schedule published on the agency's website.

Payments for the above services are based upon the appropriate published fee schedule unless a lower amount is billed by the provider.

ATTACHMENT 4.19-B
PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

5a. Physician Services

- a. Services other than clinical diagnostic laboratory tests:
 1. Payment will be the lower of billed charges or based upon a fee schedule established by the State agency for procedures provided ten or more times in the base year without a procedure modifier indicated on the claim. The fee schedule will be published on the agency's website, along with any subsequent adjustments. Payment amounts will be the same for all public and private providers.
 2. Payment for procedures provided less than ten times in the base year will be the amount allowed under the Medicare program effective January 1, 1993. If there is no Medicare fee established the payment will be 40% of billed charges.
 3. Supplies will be paid at 90% of the provider's usual and customary charge.
- b. Anesthesia services. Payment will be allowed using a \$16 unit value multiplied by a total of the base units set for the procedure plus time units using a 15-minute value.
- c. Clinical diagnostic laboratory tests:
 1. Payment will be the lower of billed charges or the fee set by Medicare.
 2. Payments will be the same for all public and private providers.
 3. Tests for which Medicare has not established a fee will be paid at 60% of billed charges.
 4. Fees will be published on the State agency's website, as well as any subsequent adjustments and updates.
- d. Deductible and co-insurance charges under the Medicare program will be paid at the amount indicated by the Medicare carrier.
- e. Payment levels for procedures reported with a procedure modifier may be paid at a lower or higher amount than the fee established in "a" or "c" above, depending on the modifier used by the provider when submitting the claim.
- f. Payment for physician services provided via telemedicine will be allowed at both the "hub" site and "spoke" sites. Each provider must bill the appropriate CPT procedure code with the modifier code "GT" indicating the services were provided via telemedicine. Only providers eligible to enroll in the Medical Assistance program are eligible for payment of telemedicine services. Reimbursement amounts for telemedicine services are based on the lesser of the fee schedule established by the State agency or the provider's usual and customary charge. Payment amounts will be the same for all public and private providers of telemedicine. The State agency will publish the fee schedule and all subsequent updates on its website.
- g. Effective July 1, 2011, through June 30, 2012, the State agency will reduce the amount of reimbursement calculated above for physicians specializing in primary care pediatrics, internal medicine, obstetrics, family practice, general practice, and osteopathy by 4.5 percent after any cost sharing amount due from the patient and any third party liability amounts have been deducted. The agency will reduce reimbursements for all other physician types by 5.1 percent.

ATTACHMENT 4.19-B
PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

9. Clinic Services

Payments for clinic services will be the same for all public and private providers by type of clinic service and are further subject to these limitations for specific types of clinic services:

a. Family planning clinics.

Payment for services will be the lowest of usual and customary charges, 80 percent of Medicare reimbursement rates, or the amount established on the State agency's website.

b. Ambulatory surgical centers.

Payments for payable procedures will be based upon group assignments which will not exceed 80 percent of Medicare reimbursements. Payment rates will be listed on the agency's website. Payable procedures include: nursing, technician, and related services; patient's use of facilities; drugs, biologicals, surgical dressings, supplies, splints, casts, and appliances and equipment directly related to the surgical procedures; diagnostic or therapeutic services or items directly related to the surgical procedures; administrative and recordkeeping services; housekeeping items and supplies; and materials for anesthesia. Items not reimbursable include those payable under other provisions of State Plan, such as physician services, laboratory services, X-ray and diagnostic procedures, prosthetic devices, ambulance services, orthotic devices, and durable medical equipment for use in the patient's home, except for those payable as directly related to the surgical procedures.

c. Endstage renal disease clinics.

Payments will be based upon Medicare principles of reimbursement and based on a fee schedule established by the State agency and published on the agency's website. Payments will not exceed the lower of 80 percent of Medicare reimbursements or usual and customary charges.

d. Indian Health Service clinics.

Payments to Indian Health Service Clinics will be per visit and based upon the approved rates published each year in the *Federal Register* by the Department of Health and Human Services, Indian Health Service, under the authority of sections 321(a) and 322(b) of the Public Health Service Act (42 U.S.C. 248 and 249(b)), Public Law 83-568 (42 U.S.C. 2001(a)), and the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.). The State agency will make payments for visits of the same type of service on the same day at the same provider location only if the services provided are different or if they have different diagnosis codes.

e. Maternal Child Health Clinics.

Payment for services will be at the lowest of usual and customary charges, 80 percent of Medicare reimbursement rates, or the amount established on the State agency's website.

The State agency will annually compare at the beginning of the State fiscal year the Medicaid payment rates for each CPT code with Medicare's published rates for the same procedures. The State agency's rates were set as of July 1, 2011, and are effective for services on or after that date. All rates are published on the State agency's website. The State agency will use computer edits to deny payment for claims which exceed 80 percent of the Medicare rate.

ATTACHMENT 4.19-B
PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

10. Dental Services

The agency's rates were set as of July 1, 2011, and are effective for services on or after that date. The agency-developed fee schedule is based upon review of the most recent year's paid claims information, national coding lists, and documentation submitted by providers and associated medical professional organizations. The fee schedule is published on the agency's website. Except as otherwise noted in the plan, the agency-developed fee schedule rates are the same for all governmental and private providers.

Payments are based upon the published fee schedule unless a lower amount is billed by the provider. Payments for selected services for children birth to age 6 and for services for developmentally disabled patients are at enhanced rates for the selected services. Payment enhancements are as follows: \$5 for examination codes, \$10 for amalgam or resin fillings codes, \$15 for pulpotomy, and \$24 for stainless a steel crown. The sum of the regular fee schedule amount and the enhanced payment may not exceed the provider's usual and customary fee. In order to qualify for the enhanced rates providers must complete a face-to-face certification course.

TN # 11-
SUPERSEDES
TN # 08-3

Approval Date _____

Effective Date 7/01/11

ATTACHMENT 4.19-B
PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

12a. Prescription Drugs

Payment will be the lower of the usual and customary charge to the general public and the upper limit for multiple source drugs as listed in Part 6 of the State Medicaid Manual plus a dispensing fee, or the estimated acquisition cost (EAC) plus a dispensing fee. In addition, the State agency will maintain a list of drugs for which payment will be limited to the lower of a state maximum allowable cost (SMAC) plus a dispensing fee or the pharmacy's usual and customary charge for the product. SMAC drugs are widely and consistently available to South Dakota pharmacies at a price that is less than average wholesale price (AWP).

The agency establishes the EAC first utilizing the monthly First DataBank listing or, for items not in the First DataBank list, the Redbook and:

1. Using the AWP less 15% for all other substances except for items listed under the SMAC; or
2. Using the average of the AWP less 15% for all generic products available for a specific drug listed on the SMAC.

The dispensing fee of \$4.30 was established using information received from participating pharmacies relative to their costs of operating the prescription department within the store and the volume of prescriptions dispensed. An additional \$.80 is added to the dispensing fee for unit dose dispensing.

ATTACHMENT 4.19-B
PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

12b. Dentures

The agency's rates were set as of July 1, 2011, and are effective for services on or after that date. The agency-developed fee schedule is based upon review of the most recent year's paid claims information, national coding lists, and documentation submitted by providers and associated medical professional organizations. The fee schedule is published on the agency's website. Except as otherwise noted in the plan, the agency-developed fee schedule rates are the same for all governmental and private providers.

Payments are based upon the published fee schedule unless a lower amount is billed by the provider. Payment amounts cover actual device and practitioner time constructing dentures.

ATTACHMENT 4.19-B
PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

12c. Prosthetic Devices

The agency's rates were set as of July 1, 2011, and are effective for prosthetic devices on or after that date. The agency-developed fee schedule is based upon review of the most recent year's paid claims information, national coding lists, and documentation submitted by providers and associated medical professional organizations. The agency publishes the fee schedule on the agency's website. Except as otherwise noted in the plan, the agency-developed fee schedule rates are the same for all governmental and private providers. Payments are based upon the published fee schedule unless the provider bills a lower amount.