DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Wells/ Bowling	10-2-06

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 000278	[X] Prepare reply for the Director's signature DATE DUE 11-2-06
2. DATE SIGNED BY DIRECTOR C: ~~Bowling~~ Kerr Singleton ✓	[ ] Prepare reply for appropriate signature DATE DUE _____ [ ] FOIA DATE DUE _____ [ ] Necessary Action

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
1. Cleared 11/2/06, letter attached			
2.			
3.			
4.			

Department of Health & Human Services
Centers for Medicare & Medicaid Services
61 Forsyth Street, S.W., Suite. 4T20
Atlanta, Georgia 30303-8909

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

September 26, 2006

Mr. Robert M. Kerr, Director
South Carolina Department of Health & Human Services
Post Office Box 8206
Columbia, South Carolina 29202-8206

Dear Mr. Kerr:

We have completed our review of State Plan Amendment (SPA) Transmittal SC 06-008, which was submitted in order to convert your Non-emergency Transportation (NET) 1915(b)(4) Waiver to a State plan service under the provisions in Section 6083 of the Deficit Reduction Act of 2005. This SPA would allow the State to operate a brokered NET system through the State Plan, but yet maintain the higher FMAP rate of the waiver. We have discussed the pending SPA with your staff and provided technical assistance to them. However, we find it is not approvable as submitted.

During the course of the review, the State submitted revised State plan pages for transportation that contained some additional transportation services that were not previously stated in the State plan. Federal regulations at § 430.10 describe the State plan as:

> …a comprehensive written statement submitted by the agency describing the nature and scope of its Medicaid program and giving assurance that it will be administered in conformity with the specific requirements of title XIX, the regulations in this Chapter IV, and other applicable official issuances of the Department. The State plan contains all information necessary for CMS to determine whether the plan can be approved to serve as a basis for Federal financial participation (FFP) in the State program.

Please provide the information below:

1. Based on proposed SPA language provided by the State, the State is reimbursing the Local Education Agencies (LEAs) for transportation of students to schools for medical services. The State is also reimbursing the LEAs for transportation of students to off-campus medical providers. Please provide a full description of the policy and payment methodology for these services.

2. Under the heading, "Other Types of Transports," the State should provide a full description of what is defined as other types of transports. In particular, provide a full description of which local private agencies provide transportation of Medicaid eligible children who require non-parental escort and how the program works. Also provide a full description of which State

Agencies provide NET self-services for transportation of special populations and how the program works.

3. Meals, Lodging, and Escorts – This must be provided in the State plan for out-of state and in-state transportation when necessary. Please provide in Attachment 3.1-A a full description of the policy and whether the broker or some other entity will provide the transports. Please provide a payment methodology for each of these services in Attachment 4.19-B of the State plan.

4. Please separate the policy for the emergency (ambulance) program and the non-emergency transportation (non-ambulance) program. Please provide a payment methodology in Attachment 4.19-B for each program as referenced above. Also, for all services paid outside the brokered arrangement, please fully describe the policy in Attachment 3.1-A, and provide a payment methodology for each of these services in Attachment 4.19-B.

5. In the first sentence on page 2 of the General Description in Attachment 3.1-A , the proposed SPA language includes the words, "other related health." Please remove these words as all of the transportation services are medical services.

6. Since the State operates a school-based administrative claiming program with the South Carolina State Department of Education, please provide language in both Attachments 3.1-A and 4.19-B that carves out or specifies that administrative costs for schools to arrange transportation are not included in the school-based transportation program provided for in the State plan and reimbursed by the State Medicaid Agency.

7. All services on the same page(s) as the proposed changes covered in the SPA must meet the requirements specified in the above referenced Federal regulation at §430.10. Item 24.g. on page 6h of the Attachment 4.19-B indicates that the State makes payments to birthing centers. Unfortunately, birthing centers are not recognized facilities eligible for a facility payment. However, payments may be made to the nurse midwife. Also, there must be a corresponding clear description in Attachment 3.1-A of the State Plan describing the policy for midwifery.

8. Also, on page 6h of the Attachment 4.19-B, item 24., the risk capitation payment language must be described.

9. Additionally, we understood the State to make a reference to a per diem payment for some transportation services. Institutional payment rates, such as per diems, recognize costs associated with facility services and as such are not economic and efficient methods to reimburse for professional services (Section 1902(a)(30) of the Act, implemented in the Federal regulations at 42 CFR 447.200). Therefore, CMS cannot accept an institutional payment as the reimbursement basis for a non-institutional service. Section 1905(a) of the Social Security Act, implemented in Federal regulations at 42 CFR 440, Subpart A, "Definitions," only list the following institutional services (where a per diem payment is appropriate):

- Inpatient hospital,

- Nursing Facilities services,
- Institutions for Mental Disease (IMDs) for individuals 65 years of age or older (optional services in a variety of settings),
- Intermediate Care Facilities for the Mentally Retarded (ICF/MRs),
- Inpatient Psychiatric Services for the under 21 year olds (also known as Psychiatric Residential Treatment Facilities or PRTFs - an optional service).

If the State is making per diem payments for transportation services, please describe the policy for those payments in Attachment 3.1-A, and revise the methodology for the per diem payments for transportation services in Attachment 4.19-B in accordance with the guidance provided above. Please describe this payment in detail.

10. If the State wishes to provide transportation to the pharmacy for the full benefit dual eligible population, it may include that language directly in this SPA rather than through a pre-print.

Since the State did not submit any Attachment 4.19-B payment pages, and all of the Attachment 3.1-A policy pages require revisions, there is much information that must be provided that has not been submitted. There may be a need for additional clarification of the State's responses. The standard funding questions below must be answered for all transportation services **except** those covered under a capitated Non-Emergency Transportation waiver.

The following funding questions are being asked and should be answered in relation to all payments made to all providers reimbursed pursuant to a methodology described in Attachment 4.19-B of this SPA. For SPAs that provide for changes to payments for clinic or outpatient hospital services or for enhanced or supplemental payments to physician or other practitioners, the questions must be answered for all payments made under the state plan for such service.

11. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by States for services under the approved State plan. Do providers retain all of the Medicaid payments including the Federal and State share (includes normal per diem, supplemental, enhanced payments, other) or is any portion of the payments returned to the State, local governmental entity, or any other intermediary organization? If providers are required to return any portion of payments, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.)

12. Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the State share of each type of Medicaid payment (normal per diem, supplemental, enhanced, other) is funded. Please describe whether the State share is from appropriations from the legislature, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs),

provider taxes, or any other mechanism used by the State to provide State share. Please provide an estimate of total expenditure and State share amounts for each type of Medicaid payment. If any of the non-Federal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the State agency receives the transferred amounts from the local government entity transferring the funds. If CPEs are used, please describe the methodology used by the State to verify that the total expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b). For any payment funded by CPEs or IGTs, please provide the following:

a. complete list of the names of entities transferring or certifying funds;
b. the operational nature of the entity (State, county, city, other);
c. the total amounts transferred or certified by each entity;
d. clarify whether the certifying or transferring entity has general taxing authority: and,
e. whether the certifying or transferring entity received appropriations (identify level of appropriations).

13. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved State plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.

14. For clinic or outpatient hospital services please provide a detailed description of the methodology used by the State to estimate the upper payment limit for each class of providers (State owned or operated, non-State government owned or operated, and privately owned or operated).

15. Does any public provider receive payments that in the aggregate (normal per diem, supplemental, enhanced, other) exceed their reasonable costs of providing services? If payments exceed the cost of services, do you recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?

If you have any questions on this request for additional information please contact Elaine Elmore on programmatic issues or Selwyn White on fiscal issues. Ms. Elmore can be reached at (404) 562-7408 and Mr. White can be reached at (404) 562-7427. This written request for additional information stops the 90-day clock for the approval process on this SPA, which would have expired on October 3, 2006. Further, in accordance with the CMS guidelines to all State Medicaid Directors dated January 2, 2001, we request that you provide a formal response to this request for additional information no later than 90 days from the date of this letter. If you do not provide us with a formal response by that date, we will conclude that the State has not established that the proposed SPA is consistent with all statutory and regulatory requirements. Accordingly, at that time, we will initiate disapproval action on the amendment. In addition, because this SPA was submitted after January 2, 2001, and is effective on or after January 1, 2001, please be advised that we will defer any FFP that you claim for payments made in

accordance with this proposed SPA until it is approved. Upon CMS approval, FFP will be available for the period beginning with the effective date through the date of actual approval.

Sincerely,

Renard L. Murray

Renard L. Murray, D. M.
Associate Regional Administrator
Division of Medicaid and Children's Health

Log 0278

State of South Carolina
Department of Health and Human Services

Mark Sanford
Governor

Robert M. Kerr
Director

November 2, 2006

Mr. Renard Murray
Associate Regional Administrator
Center for Medicare and Medicaid Services
Division of Medicaid & Children's Health
Atlanta Regional Office
61 Forsyth Street, SW- Suite 4T20
Atlanta, Georgia 30303-8909

RE: South Carolina Title XIX State Plan Amendment SC 06-008 RAI

Dear Mr. Murray:

The South Carolina Department of Health and Human Services (SCDHHS) is providing pages 9c through 9h of Attachment 3.1-A and pages 6h through 6h.4. of Attachment 4.19-B that address questions #1,2,3,4,5,6,and 10 of the subject RAI. Additionally, the state is requesting assistance from CMS that will allow us to transition from a facility payment to an acceptable nurse midwife payment that would cover both the technical and professional component of births in birthing centers as discussed in question #7. In regards to question #9, the SCDHHS believes that the use of a daily route rate for special needs transportation services is an appropriate and acceptable method to use for rate setting/payment purposes, as other alternative unit measures would result in overly burdensome paperwork requirements.

The responses to the CMS funding questions are provided below:

CMS QUESTION #1:

Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by States for services under the approved State plan. Do providers retain all of the Medicaid payments including the Federal and State share (includes normal per diem, supplemental, enhanced payments, other) or is any portion of the payments returned to the State, local governmental entity, or any other intermediary organization? If providers are required to return any portion of payments, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.)

SCDHHS Response:

Providers receiving payment under SC 06-008 retain one hundred percent of the Medicaid payments.

Office of the Director
P.O. Box 8206 • Columbia, South Carolina 29202-8206
(803) 898-2504 • Fax (803) 255-8235

CMS QUESTION #2:

Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state share of each type of Medicaid payment (normal per diem, supplemental, enhanced, other) is funded. Please describe whether the state share is from appropriations from the legislature, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Please provide an estimate of total expenditure and State share amounts for each type of Medicaid payment. If any of the non-federal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the state agency receives the transferred amounts from the local government entity transferring the funds. If CPEs are used, please describe the methodology used by the state to verify that the total expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b). For any payment funded by CPEs or IGTs, please provide the following:

(i) a complete list of the names of entities transferring or certifying funds;

(ii) the operational nature of the entity (state, county, city, other);

(iii) the total amounts transferred or certified by each entity;

(iv) clarify whether the certifying or transferring entity has general taxing authority: and,

(v) whether the certifying or transferring entity received appropriations (identify level of appropriations).

SCDHHS Response:

Service/Payment Program	Source of Funding
Emergency and Non-Emergency Ambulance Services	State Appropriations and allocation of Hospital Provider Tax
Special Needs Transportation	CPE from SDE which is actually State Appropriations
Special Populations – Private Providers	State Appropriations and Private Donations from United Way
Special Populations – State Agencies	CPE from COC, DMH, DSS, and Wil Lou Gray which is actually State Appropriations. IGTs from SCD&B
Special Populations - LEAs	Intergovernmental Transfers (IGTs)
Individual Transportation Providers	State Appropriations and allocation of Hospital Provider Tax
Out of State Transportation	State Appropriations and allocation of Hospital Provider Tax

The State Department of Education (SDE), Continuum of Care (COC), Department of Mental Health (DMH), Department of Social Services (DSS), and Wil Lou Gray use certified public expenditures (CPE) as the source of state matching funds. Annual cost reports are used for rate setting, cost settlement, and as documentation of CPE. The Internal Audit Division within SCDHHS is planning to conduct audits of state agency Medicaid services during SFY 2007. Additionally, new CPE contract language has been developed and has been/will be incorporated into each of the agency's contract:

"SDE/COC/DMH/DSS/Wil Lou Gray agrees to incur expenditures from state appropriated funds and/or funds derived from tax revenue in an amount at least equal to the non-federal share of the allowable, reasonable and necessary cost for the provision of services to be provided to Medicaid recipients under this contract prior to submitting claims for payment under this contract. Documentation of the non-federal expenditures necessary to support the claims for reimbursement must be maintained by SDE/COC/DMH/DSS/Wil Lou Gray and are subject to audit by SCDHHS. SCDHHS may withhold and/or recoup reimbursements if Certified Public Expenditures are not adequately documented. As required by 45 CFR Part 201.5, all funds expended for the non-federal share of this contract must be in compliance with 42 CFR Part 433 Subpart B. Such non-federal funds must be actually expended for the provision of services to be provided under this contract."

A schedule detailing an estimate of total expenditures and state share amounts for non-broker non-emergency transportation services is enclosed.

CMS QUESTION #3:

Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.

SCDHHS Response:

Supplemental payments which are actually retrospective cost settlements may be made to the South Carolina Department of Education for Special Needs Transportation services if the desk review of the year end cost report substantiates a supplemental payment. The last supplemental payment made to SDE for these services amounted to approximately $185,000.

CMS QUESTION #4:

Does any public provider receive payments that in the aggregate (normal per diem, supplemental, enhanced, other) exceed their reasonable costs of providing services? If payments exceed the cost of services, do you recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?

SCDHHS Response:

In the event that a state owned or local education agency is reimbursed for non-broker non-emergency transportation services in excess of allowable Medicaid costs, the SCDHHS will recoup the excess and return the federal share of the excess to CMS via the quarterly expenditure report.

If as a result of CMS review of the enclosed information there are questions relating to the programmatic and reimbursement language relating to the non-broker transportation services, then SCDHHS requests that CMS separate the broker and non-broker transportation SPA language into "A" and "B" versions in order to allow the SCDHHS to award the broker transportation contract to the winning bidder.

If you should have any questions, please contact Mr. Jeff Saxon, Bureau of Reimbursement Methodology and Policy, at (803) 898-1023. Your timely review of this RAI response will be greatly appreciated.

Sincerely,

Robert M. Kerr
Director

RMK/wsw
Enclosures