DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Wells	3-12-09

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 101502	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR cc: Ms. Forkner, DCPS cleared 9/17/09, letter attached.	[X] Prepare reply for appropriate signature DATE DUE 4-16-09
	[ ] 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.			
2.			
3.			
4.			

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

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

March 11, 2009

Ms. Emma Forkner, Director
South Carolina Department of Health and Human Services
Post Office Box 8206
Columbia, South Carolina 29202-8206

Dear Ms. Forkner:

We have reviewed the proposed State Plan Amendment (SPA) SC 08-030 Private Duty Nursing Services, which was submitted in order to revise the reimbursement for home based private duty nursing services. This SPA was received in the Regional Office on December 18, 2008 and will reach the 90th day on March 18, 2009. In order for the Centers for Medicare & Medicaid Services (CMS) to better understand the services and reimbursement proposed by the State in SC 08-030, we are submitting this Request for Additional Information (RAI). We are available to discuss any question the State may have about the RAI.

In order to determine whether the SPA can be approved, we require more information about the services and payment methodology. We review SPAs in the context of the overall State plan for consistency with the requirements of Section 1902(a) of the Social Security Act. In reviewing payment methodology, we also independently review the State plan coverage provisions to determine whether the payments are related to allowable Medicaid covered services. Similarly, in reviewing coverage provisions, we independently review the corresponding State plan reimbursement provisions to determine whether the State plan provides for a method of payment for those services that meets statutory and regulatory requirements. In addition, all services or payment methodologies on the same page(s) of the existing State Plan will be reviewed in the same way as the proposed changes covered in the SPA, and these existing services or payments must meet the same requirements as the proposed changes.

General Questions

1) The State is revising the reimbursement methodology for private duty nursing, and consequently, a public notice will be required that is consistent with 42 CFR 447.205. The State requested an effective date of February 1, 2009 for this SPA; however, the State has not submitted a public notice pertaining to this SPA. In the absence of a public notice dated January 31, 2009 or earlier, the February 1, 2009 effective date is problematic. Has the State published a public notice? If so, please supply a copy to CMS. If not, when does the State expect to publish the notice and what effective date will the State be seeking for SPA 08-030?

2) There is a generalized lack of clarity in both coverage and reimbursement concerning Personal Care services. The State is not consistent in the use of its terms and the definitions across both coverage and reimbursement. There will be questions later in this letter that asks the State to make both the service and the reimbursement language clear.

Ms. Emma Forkner
March 11, 2009

Coverage Questions:

1.) Please add language in the SPA that the private duty nursing services meet the requirements at 42 CFR 440.80.

2.) On Attachment 3.1-A, page 1c, the State changed the language in the first paragraph to read, "The services must be ordered by the attending physician and must be provided by a Licensed Practical Nurse (LPN) or a Registered Nurse (RN), licensed by the State Board of Nursing for South Carolina (or equivalent in GA and NC)."

a. Why does the State reference the nursing qualifications for GA and NC and thereby appear to want nurses licensed in GA and NC to be able to provide private duty nursing in South Carolina?

b. The CMS is concerned with the provisions of the SC licensure law. Does the South Carolina licensure law for nurses recognize licenses from other states such as GA and NC? The State Plan must agree with the State's licensure law. If the State's licensure law does not allow nurses licensed in other states to practice in South Carolina, then the State Plan cannot allow nurses to provide medical services and receive reimbursement under Medicaid, thereby bypassing the State licensure laws.

3.) In order to be consistent with the name "Home Based Private Duty Nursing Services" on page 2 of Attachment 4.19-B, the State should preface the references to private duty nursing on page 1c of Attachment 3.1-A with "home-based".

4.) Under personal care services found on page 1c and elsewhere in Attachment 3.1-A, please include the following in the SPA:

a. The definition of personal care services (PCS), i.e., whether it includes all or one of assistance with ADLs, IADLs, cueing or supervision;

b. Whether PCS are furnished in the beneficiary's home or also in another community location;

c. The practitioners that are qualified to furnish PCS; and

d. The practitioners' qualifications. The practitioner qualifications should include the level of education/degree required, and any additional general information related to licensing, credentialing, or registration. The practitioner qualifications should also reference any required supervision.

c. Please re-title "Personal Care (Aide) Services" in the new 4.19-B reimbursement page, page 2.1, as "Personal Care Services" as there is no service called "Personal Care (Aide) Services".

d. Please explain why the State uses the terms "Personal Care I and Personal Care II services" in the new 4.19-B reimbursement page, page 2.1, instead of "Personal Care Services."

5.) Please explain what the State means by "integrated personal care services" that appears as a rehabilitative service on pages 6d and 6e of Attachment 3.1-A and how it is different than personal care services under EPSDT on page 1c of Attachment 3.1-A.

6). Please delete reference in the SPA to "all licensed practitioners" in paragraph 4 of Attachment 3.1-A for physical and occupational therapy services. Retain the language in the SPA that licensed physical and occupational therapists furnish these services, but please add language that physical and occupational therapy are provided by or under the direction of qualified therapists and that the physical therapy and occupational therapy services meet the requirements of 42 CFR 440.110.

Attachment 4.19-B

1.) Please provide the Federal Budget impact calculation.

2.) It appears that the state is changing Private Duty Nursing so that it only affects those services provided in the home. Is this what the state intends?

3.) Please include the latest version of the effective date/fee schedule language both under the section "home based private duty nursing services" on page 2 of att. 4.19-B and for "personal care (Aides) services located on the succeeding page. The State should remove the older version of this language from the state plan. The latest version is the following:

> "Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of *(ex. case management for persons with chronic mental illness)*. The agency's fee schedule rate was set as of *(insert date here)* and is effective for services provided on or after that date. All rates are published *(ex. on the agency's website)*."

4.) What is the process the provider must undertake to receive the higher rate for highly skilled nurses? For example, is there a special code that must be billed?

5.) Please provide a copy of the actual rate schedule paid for both Private Duty Nursing and Personal Care.

6.) The State references on the page 2.1"...based on the intensive technical services reimbursement rate as established via Attachment 4.19-D." Since Attachment 4.19-D of the State Plan is very large (over 40 pages), the State should include a more definitive location in 4.19-D, or reiterate the methodology on this new 4.19-B page 2.1.

7.) Page 2 of Attachment 4.19-B is also included in SPA SC 08-004, which is currently off the clock because a request for additional information was issued to the State on August 25, 2008. We cannot process SPA pages out of turn, and therefore cannot approve page 2 of Attachment 4.19-B in this SPA, SC 08-030 until SC 08-004 is processed.

Standard Funding Questions

The State has not answered the standard funding questions with respect to the services included in this proposed SPA. Please answer the Standard Funding Questions listed below:

The following 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.

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 receive and retain the total Medicaid expenditures claimed by the State (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.)

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 to the Medicaid agency, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either through an IGT or CPE. In this case, please identify the agency to which the funds are appropriated. 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 governmental 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).

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.

4. For clinic or outpatient hospital services please provide a detailed description of the methodology used by the state to estimate the upper payment limit (UPL) for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated). Please provide a current (i.e., applicable to the current rate year) UPL demonstration.

5. Does any governmental 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 related on this request for additional information please contact Tandra Hodges on programmatic issues or Philip Bailey on fiscal issues. Ms. Hodges can be reached at 404-562-7409, and Mr. Bailey can be reached at 615-255-9305. This written request for additional information stops the 90-day clock for the approval process on this SPA, which would have expired on March 18, 2009. Upon CMS approval, FFP will be available for the period beginning with the effective date through the date of actual approval.

Sincerely,

Mary Kaye Justis, RN, M.B.A.
Acting Associate Regional Administrator
Division of Medicaid and Children's Health Operations

Pg 502

State of South Carolina
Department of Health and Human Services

Mark Sanford
Governor

Emma Forkner
Director

September 17, 2009

Ms. Mary Kaye Justis, RN, MBA
Acting Associate Regional Administrator
Division of Medicaid and Children's Health Operations
Centers for Medicare and Medicaid Services
61 Forsyth St., Suite 4T20
Atlanta, Georgia 30303-8909

RE: South Carolina Title XIX State Plan Amendment SC 08-030 Request for Additional Information (RAI)

Dear Ms. Justis:

This is in response to the subject Request for Additional Information dated March 11, 2009 relating to SC 08-030.

General Questions

1) The State is revising the reimbursement methodology for private duty nursing, and consequently, a public notice will be required that is consistent with 42 CFR 447.205. The State requested an effective date of February 1, 2009 for this SPA; however, the State has not submitted a public notice pertaining to this SPA. In the absence of a public notice dated January 31, 2009 or earlier, the February 1, 2009 effective date is problematic. Has the State published a public notice? If so, please supply a copy to CMS. If not, when does the State expect to publish the notice and what effective date will the State be seeking for SPA 08-030?

SCDHHS Response:

Public notices were published on April 25 and 28, 2009 (copy enclosed). DHHS is requesting coverage of this SPA 08-030 back to the date of May 1, 2009.

2) There is a generalized lack of clarity in both coverage and reimbursement concerning Personal Care services. The State is not consistent in the use of its terms and the definitions across both coverage and reimbursement. There will be questions later in this letter that asks the State to make both the service and the reimbursement language clear.

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

Coverage Questions:

1.) Please add language in the SPA that the private duty nursing services meet the requirements at 42 CFR 440.80.

SCDHHS Response:

Language has been added to SPA 08-030, Attachment 3.1-A, page 1c to indicate the private duty nursing services are in compliance with the requirements of 42 CFR 440.80.

2.) On Attachment 3.1-A, page 1c, the State changed the language in the first paragraph to read, "The services must be ordered by the attending physician and must be provided by a Licensed Practical Nurse (LPN) or a Registered Nurse (RN), licensed by the State Board of Nursing for South Carolina (or equivalent in GA and NC)."

a. Why does the State reference the nursing qualifications for GA and NC and thereby appear to want nurses licensed in GA and NC to be able to provide private duty nursing in South Carolina?

SCDHHS Response:

The State is removing the reference to Georgia and North Carolina from this amendment. South Carolina is part of the nursing compact where reciprocity is available for North Carolina but any nurse licensed in Georgia must also maintain a South Carolina license in order to provide services for South Carolina Medicaid participants.

b. The CMS is concerned with the provisions of the SC licensure law. Does the South Carolina licensure law for nurses recognize licenses from other states such as GA and NC? The State Plan must agree with the State's licensure law. If the State's licensure law does not allow nurses licensed in other states to practice in South Carolina, then the State Plan cannot allow nurses to provide medical services and receive reimbursement under Medicaid, thereby bypassing the State licensure laws.

SCDHHS Response:

The State is removing the reference to Georgia and North Carolina from this amendment. South Carolina is part of the nursing compact where reciprocity is available for North Carolina but any nurse licensed in Georgia must also maintain a South Carolina license in order to provide services for South Carolina Medicaid participants.

3.) In order to be consistent with the name "Home Based Private Duty Nursing Services" on page 2 of Attachment 4.19-B, the State should preface the references to private duty nursing on page 1c of Attachment 3.1-A with "home-based".

SCDHHS Response:

"Home-Based" has been added to the service name references in section 3.1-A, page 1c, in order that there is consistency between the service names in the coverage and reimbursement sections of the State Plan.

4.) Under personal care services found on page 1c and elsewhere in Attachment 3.1-A, please include the following in the SPA:

a. The definition of personal care services (PCS), i.e., whether it includes all or one of assistance with ADLs, IADLs, cueing or supervision;

SCDHHS Response:

Please see Attachment 3.1-A, page 1c, of the SPA for the revised definition of personal care services.

b. Whether PCS are furnished in the beneficiary's home or also in another community location;

SCDHHS Response:

Please see Attachment 3.1-A, page 1c, of the SPA for the service delivery sites of personal care services.

c. The practitioners that are qualified to furnish PCS; and

SCDHHS Response:

Please see Attachment 3.1-A, page 1c, of the SPA for the practitioners qualified to furnish personal care services.

d. The practitioners' qualifications. The practitioner qualifications should include the level of education/degree required, and any additional general information related to licensing, credentialing, or registration. The practitioner qualifications should also reference any required supervision.

SCDHHS Response:

Please see Attachment 3.1-A, page 1c, of the SPA for the qualifications required to furnish personal care services.

c. Please re-title "Personal Care (Aide) Services" in the new 4.19-B reimbursement page, page 2.1, as "Personal Care Services" as there is no service called "Personal Care (Aide) Services".

SCDHHS Response:

This section has been re-titled "Personal Care Services" on the revised page 2.1 of 4.19-B.

d. Please explain why the State uses the terms "Personal Care I and Personal Care II services" in the new 4.19-B reimbursement page, page 2.1, instead of "Personal Care Services."

SCDHHS Response:

Personal Care II services are those services that are known as Activities of Daily Living (ADL's). Children's Personal Care services are only authorized and billed if Activities of Daily Living are

required by the participant. Instrumental Activities of Daily Living (IADL's), known as Personal Care I, may be done as an adjunct to the tasks involved in performing the ADL's but are not billed separately under the children's personal care service.

Note: Billable PC I services are available only through our waiver programs to elderly beneficiaries.

5.) Please explain what the State means by "integrated personal care services" that appears as a rehabilitative service on pages 6d and 6e of Attachment 3.1-A and how it is different than personal care services under EPSDT on page 1c of Attachment 3.1-A.

SCDHHS Response:

The term Integrated Personal Care (IPC) is used by the State in reference to personal care services provided to residents of community residential care facilities who are Medicaid eligible through their participation in the Optional State Supplementation (OSS) program. These residents are identified through a medical assessment to have a minimum of two functional dependencies or one functional dependence and cognitive impairment. The personal care services provided to these residents are based on the individual's needs and set forth in a care plan developed by a registered nurse. All of the requirements of 42 CFR 440.167 are met. The state is currently working with CMS on SPA 08-024 and has responded to numerous questions about this service.

6). Please delete reference in the SPA to "all licensed practitioners" in paragraph 4 of Attachment 3.1-A for physical and occupational therapy services. Retain the language in the SPA that licensed physical and occupational therapists furnish these services, but please add language that physical and occupational therapy are provided by or under the direction of qualified therapists and that the physical therapy and occupational therapy services meet the requirements of 42 CFR 440.110.

SCDHHS Response:

Please see Attachment 3.1-A, page 1c, of the SPA for the requested changes. All of the requirements of 42 CFR 440.110 are met.

Attachment 4.19-B

1.) Please provide the Federal Budget impact calculation.

SCDHHS Response:

The Federal Budget impact is attached. Please note it has been revised to reflect the new effective date of the SPA, May 1, 2009.

2.) It appears that the state is changing Private Duty Nursing so that it only affects those services provided in the home. Is this what the state intends?

SCDHHS Response:

Yes, the State intends to provide this service in the home. This service is distinguished from other nursing services like school based or home health nursing services and will be provided in the home setting.

3.) Please include the latest version of the effective date/fee schedule language both under the section "home based private duty nursing services" on page 2 of att. 4.19-B and for "personal care (Aides) services located on the succeeding page. The State should remove the older version of this language from the state plan. The latest version is the following:

> "Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of *(ex. case management for persons with chronic mental illness)*. The agency's fee schedule rate was set as of *(insert date here)* and is effective for services provided on or after that date. All rates are published *(ex. on the agency's website)*."

SCDHHS Response:

The latest version of the effective date/fee schedule language has been inserted into page 2.1 under Home Based Private Duty Nursing services and Personal Care Services.

4.) What is the process the provider must undertake to receive the higher rate for highly skilled nurses? For example, is there a special code that must be billed?

SCDHHS Response:

SCDHHS' Community Long Term Care Bureau serves as the gatekeeper for EPSDT children (under 21), who require private duty nursing services. Private Duty Nursing services, regular or enhanced, are prior authorized by the child's CLTC nurse. These services are provided by and reimbursed to providers who utilize the CLTC's Care Call system. Note: The Care Call system is an automated system used for service documentation, service monitoring, web-based reporting, and billing to MMIS. Care Call utilizes programmed code lists and rates for authorized services that are "called in" at the time of service.

State plan private duty nursing services are also provided to children who are a part of SCDDSN's waiver programs (MR/RD and to a lesser degree HASCI). These private duty nursing services are prior authorized by SCDDSN staff. These services are provided by and reimbursed to nursing service providers who are directly enrolled with SCDHHS. In these instances however, Care Call is not used. Providers of service bill MMIS directly using separate procedure codes and rates to distinguish the regular and enhanced nursing services as well as identify these services to the DDSN waiver population.

5.) Please provide a copy of the actual rate schedule paid for both Private Duty Nursing and Personal Care.

SCDHHS Response:

Children – SCDHHS CLTC program (i.e. Care Call)

Procedure Code	Description	Effective Date	Rate	Unit Measure
T1002	RN Nursing - Regular	07/01/07	$33.00 (hourly)	See note below
	RN Nursing - Enhanced	05/01/09	$36.00 (hourly)	
T1003	LPN Nursing – Regular	07/01/07	$25.00 (hourly)	See note below
	LPN Nursing – Enhanced	05/01/09	$28.00 (hourly)	
T1019	Personal Care Services	10/01/07	$16.00 (hourly)	See note below

Note: Services billed through the SCDHHS Care Call system are eligible to be paid in six-minute increments (or ten units = 1 hour of service).

Children – SCDDSN Waiver programs (i.e. State Plan services)

Procedure Code	Description	Effective Date	Rate	Unit Measure
S9123	RN Nursing - Regular	07/01/07	$33.00 (hourly)	See note below
T1002/ S9123-TG	RN Nursing - Enhanced	05/01/09	$36.00 (hourly)	
S9124	LPN Nursing – Regular	07/01/07	$25.00 (hourly)	See note below
T1003/ S9124-TG	LPN Nursing – Enhanced	05/01/09	$28.00 (hourly)	
T1019/	Personal Care Services	10/01/07	$16.00 (hourly)	See note below

Note 1: Services billed through the SCDHHS MMIS for these State Plan services are eligible to be paid in fifteen-minute increments (or four units = 1 hour of service).

Note 2: T1002 (RN Enhanced Nursing Services) – used for MR/RD waiver beneficiaries. S9123-TG (RN Enhanced Nursing Services) – used for HASCI waiver beneficiaries.

Note 3: T1003 (LPN Enhanced Nursing Services) – used for MR/RD waiver beneficiaries. S9124-TG (LPN Enhanced Nursing Services) – used for HASCI waiver beneficiaries.

6.) The State references on the page 2.1"...based on the intensive technical services reimbursement rate as established via Attachment 4.19-D." Since Attachment 4.19-D of the State Plan is very large (over 40 pages), the State should include a more definitive location in 4.19-D, or reiterate the methodology on this new 4.19-B page 2.1.

SCDHHS Response:

The location of the intensive technical services reimbursement methodology has been included in the revised version of SC 08-030, Attachment 4.19-B, page 2.1.

7.) Page 2 of Attachment 4.19-B is also included in SPA SC 08-004, which is currently off the clock because a request for additional information was issued to the State on August 25, 2008. We cannot process SPA pages out of turn, and therefore cannot approve page 2 of Attachment 4.19-B in this SPA, SC 08-030 until SC 08-004 is processed.

SCDHHS Response:

SPA 08-004 was approved on July 20, 2009.

In regards to the CMS funding questions, we are providing the following information:

CMS Funding 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 receive and retain the total Medicaid expenditures claimed by the State (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:
All Medicaid providers reimbursed for the services addressed in state plan MA 08-030 retain one hundred percent of the Medicaid payments that they receive.

CMS Funding 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 to the Medicaid agency, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either an IGT or CPE. In this case, please identify the agency to which the funds are appropriated. 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
Private Duty Nursing Services – Claim Payments	State Appropriations included in SCDHHS budget
Private Providers	State Appropriations included in SCDDSN budget

An estimate of total expenditures and state share amounts based upon state fiscal year 2008 Medicaid expenditures is enclosed.

CMS Funding 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:
There are no supplemental or enhanced payment programs for the services described via state plan MA 08-030.

CMS Funding Question #4:
For clinic or outpatient hospital services, please provide a detailed description of the methodology used by the state to estimate the upper payment limit (UPL) for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated). Please provide a current (i.e. applicable to the current rate year) UPL demonstration.

SCDHHS Response:
This question is not applicable to MA 08-030.

CMS Funding Question #5:
Does any governmental 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:
There are no public providers of home based private duty nursing services.

In relation to the coverage and reimbursement pages that include sections related to this state plan amendment, the state is in compliance with the terms of the American Recovery and Reinvestment Act (ARRA) concerning:

1. Maintenance of Effort;
2. State or local match;
3. Prompt payment;
4. Rainy day funds; and
5. Eligible expenditures (e.g. no DSH or other enhanced match payments).

We look forward to approval of SC 08-030. If you should have any questions, please contact Sam Waldrep at (803) 898-2725 or Jeff Saxon at (803) 898-1023.

Sincerely,

Emma Forkner
Director

EF/wsh
Enclosures