DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Wells	1-20-09

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 000387	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR _____	[ ] Prepare reply for appropriate signature DATE DUE 4-15-09
cc: Emma Dups Cleared 7/31/09, letter attached.	[ ] 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 St., Suite 4T20
Atlanta, Georgia 30303-8909

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

January 14, 2009

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

Re: Request for Additional Information, SPA 08-026

Dear Ms. Forkner:

We have reviewed the proposed State Plan Amendment (SPA) 08-026, which was submitted in order to update the private rehabilitative and school-based therapy rates effective October 1, 2008 to 95% of the 2008 Medicare Fee Schedule. In order for CMS to better understand the services and reimbursement methodology proposed by the State in SC 08-026, we are submitting this Request for Additional Information (RAI). We are available to discuss any questions the State may have about the RAI.

Please provide the clarifications requested below:

1. Attachment 4.19-B, Page 2a, Payment Methodologies for Therapy Services: In an October 16, 2008 cover letter, the SC SMD indicates that this SPA's purpose is to reduce the private rehabilitative and school based therapy rates from 100% to 95% (rather than creating a range) of the 2008 Medicare Fee Schedule. However, the new reimbursement language on the proposed SPA page 2a provides for reimbursement of private and governmental providers on or after October 1, 2008 "using updated rates that will not exceed 100% of Medicare."

The preceding underlined language would result in Paragraph 2a not providing a comprehensive description of the reimbursement methodology to be utilized, as providers would not be on notice as to the exact peg to Medicare. Consequently, CMS is requesting that the State remove the "will not exceed" language and specify the percentage of Medicare paid to providers.

Please note that the fee schedule language is not necessary if the state indicates the exact percentage of Medicare and there is no manipulation of Medicare's underlying component parts of the fee (i.e. use of a different conversion factor) However, if the state does modify the component parts of Medicare's fee schedule then the state would have to explain that methodology in the state plan and include the following language. This language would require the state to submit a new state plan with a new effective date each time the fee schedule was changed:

> "The agency's fee schedule rate was set as of (date here) and is effective for services provided on or after that date. All rates are published on the agency's website."

2. Attachment 4.19-B, Page 2a, Payment Methodologies for Therapy Services
The new reimbursement language on the proposed SPA page 2a provides for reimbursement of private and governmental providers on or after October 1, 2008 "using updated rates that will not exceed 100% of Medicare. This appears to conflict with the preceding language in the state plan that reimburses at 100% of the South Carolina Medicare Physician Fee schedule effective January 1, 2007. Please remove the methodology that is not in effect.

3. Attachment 4.19-B, Page 2a, A., Calculation of Therapy Rates with No Corresponding Medicare Rate, (last sentence in first paragraph under this heading)

This language is not comprehensive as it is unclear as to "when updates are made to these rates in the future. . ." How often are rates updated? The plan language should provide some basis of how the state will use "more current claims and charge data as well as a more recent version of the Medicare RBRVS. . ." It appears the language, as written, would allow sporadic updates.

4. CMS 179 Form. The CMS 179 Form indicates an anticipated negative federal budget impact, of ($1,500,000) in FYs 2009 and 2010. Please provide an explanation of how this estimated budget impact was derived.

Standard Funding Questions. 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 to this request for additional information, please contact Mark Halter on financial issues or Elaine Elmore on programmatic issues. Mr. Halter can be reached at 404-562-7419 and Ms. Elmore can be reached at 404-562-7408. This written request for additional information stops the 90-day clock for the approval process on this SPA, which would have expired on January 14, 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, MBA
Acting Associate Regional Administrator
Division of Medicaid and Children's Health Operations

Log 387

State of South Carolina
Department of Health and Human Services

Mark Sanford
Governor

Emma Forkner
Director

July 31, 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 08-026 Request for Additional Information (RAI)

Dear Ms. Justis:

This is in response to the subject Request for Additional Information dated January 14, 2009 relating to SC 08-026.

CMS Question #1 - Attachment 4.19-B, Page 2a, Payment Methodologies for Therapy Services:
In an October 16, 2008 cover letter, the SC SMD indicates that this SPA's purpose is to reduce the private rehabilitative and school based therapy rates from 100% to 95% (rather than creating a range) of the 2008 Medicare Fee schedule. However, the new reimbursement language on the proposed SPA page 2a provides for reimbursement of private and governmental providers on or after October 1, 2008 "using updated rates that will not exceed 100% of Medicare".

The preceding underlined language would result in Paragraph 2a not providing a comprehensive description of the reimbursement methodology to be utilized, as providers would not be on notice as to the exact peg to Medicare. Consequently, CMS is requesting that the State remove the "will not exceed" language and specify the percentage of Medicare paid to the providers.

Please note that the fee schedule language is not necessary if the state indicates the exact percentage of Medicare and there is no manipulation of Medicare's underlying component parts of the fee (i.e. use of a different conversion factor). However, if the state does modify the component parts of Medicare's fee schedule then the state would have to explain that methodology in the state plan and include the following language. This language would require the state to submit a new state plan with a new effective date each time the fee schedule was changed:

> "The agency's fee schedule rate was set as of (date here) and is effective for services provided on or after that date. All rates are published on the agency's website".

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(803) 898-2504 • Fax (803) 255-8235

SCDHHS Response:
The SCDHHS has adjusted the reimbursement language in question. Please see the enclosed page 2a of Attachment 4.19-B which reflects the change.

CMS Question #2 - Attachment 4.19-B, Page 2a, Payment Methodologies for Therapy Services:
The new reimbursement language on the proposed SPA page 2a provides for reimbursement of private and governmental providers on or after October 1, 2008 "using updated rates that will not exceed 100% of Medicare. This appears to conflict with the preceding language in the state plan that reimburses at 100% of the South Carolina Medicare Physician Fee schedule effective January 1, 2007. Please remove the methodology that is not in effect.

SCDHHS Response:
SCDHHS has adjusted the methodology as reflected on the enclosed page 2a of Attachment 4.19-B as referenced in1 above. However, please note that we did not reduce the percentage allowance of the Medicare fee schedule amounts used in the determination of the psychological evaluation and testing and orientation and mobility services rates. Therefore, we left the January 1, 2007 effective date language in the plan amendment to cover the services that were not impacted October 1, 2008.

CMS Question #3 - Attachment 4.19-B, Page 2a,A – Calculation of Therapy rates with no Corresponding Medicare Rate (last sentence in first paragraph under this heading:
This language is not comprehensive as it is unclear as to "when updates are made to these rates in the future..". How often are rates updated? The plan language should provide some basis of how the state will use "more current claims and charge data as well as a more recent version of the Medicare RBRVS..". It appears the language, as written, would allow sporadic updates.

SCDHHS Response:
The SCDHHS reviews the therapy rates with no corresponding Medicare rate each time there is a need to update therapy rates that have a corresponding Medicare rate. Additionally, these rates would be reviewed at any time a reimbursement or programmatic issue arises. As a result of the implementation of the October 1, 2008 rate update and our review of the updated charge structure, we saw no need to adjust the rates in question.

CMS Question #4 – CMS 179 Form:
The CMS 179 Form indicates an anticipated negative federal budget impact, of ($1,500,000), in FYs 2009 and 2010. Please provide an explanation of how this estimated budget impact was derived.

SCDHHS Response:
First, the SCDHHS, via its Medstat reporting system, determined the number of physical, speech, and occupational therapy units and payments (by fund code) that were paid during SFY 2007/2008. Next, we multiplied the number of units by the difference in the SC 08-026 rates and the SC 07-001 rates to determine the financial impact of SC 08-026.

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:
Under SC 08-026, providers of services under this plan retain 100% of the fee schedule payments that will be reimbursed under this state plan amendment effective October 1, 2008.

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:

Physical, Speech, and Occupational Therapy Payments	State Appropriations to the Medicaid Agency and IGTs from the SC Department of Disabilities and Special Needs and the SC Dept. of Education Which are State Appropriations

The SC Department of Disabilities and Special Needs (SCDDSN) and the SC Department of Education (SCDOE), via IGTs, transfer state appropriations for physical, speech, and occupational therapy services provided by both private and governmental providers of therapy services for their Medicaid eligible population. The SCDDSN and the SCDOE are required to transfer the state matching funds in advance, prior to the Medicaid enrolled providers of therapy services submitting their claims for Medicaid reimbursement.

A schedule detailing the information requested in items (i) through (v) is enclosed. Also, a schedule detailing an estimate of total expenditures and state share amounts for each type of Medicaid payment under SC 08-026 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 payments made to private or governmental providers of therapy services under this specific plan amendment.

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:
Not applicable.

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:
It is anticipated that the payments received by private and governmental providers of therapy services under SC 08-026 would not exceed the reasonable costs of providing the 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 08-026. If you should have any questions, please contact Mr. Jeff Saxon, Bureau of Reimbursement Methodology and Policy at (803) 898-1023.

Sincerely,

Emma Forkner
Director

EF/wsw
Enclosures