DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Hess/FOIA	2-1-12

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 10-299	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR cc: Mr. Keck, Singleton, Stensland See attached e-mail Cleared 2/24/12, letter attached.	[ ] Prepare reply for appropriate signature DATE DUE _____ [X] FOIA DATE DUE 2/13/12 [ ] 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.			

BESLER
CONSULTING

CONSULTANTS IN HEALTHCARE
FINANCE AND OPERATIONS
toll free 1.877.4BESLER
www.beslerconsulting.com

January 27, 2012

ATTN: Director - Office of Medicaid
South Carolina Health & Human Services
1801 Main Street
Columbia, SC 29202

Freedom of Information Request

Dear Sirs/Madames:

Pursuant to S.C. Code Ann. Sec 30-4-10. open records law of citizens to access public information, Besler Consulting requests access to certain documents and information. Besler Consulting is a health care consulting company that accumulates on a yearly basis, Medicare disproportionate share hospital (DSH) listings for acute care hospitals. To perform our services properly, and to ensure that the hospitals in your State receive full and proper Medicare DSH reimbursement, we need certain Medicaid information as it applies to the types of Medicaid programs that exist in your State.

The basis of the Medicare DSH lists is those patients who were Medicaid eligible in the specific fiscal year. Currently, the reimbursement a hospital receives for Medicare DSH can be significant, depending on the volume of Medicaid eligible patients serviced at the hospital.

In December, 1999 the Centers for Medicare and Medicaid Services (CMS) issued Program Memorandum A-99-62 (attached), advising providers which Medicaid programs were includable in the Medicare DSH calculation and which were not. Each State has its own Medicaid programs, and this information is State-specific and must be obtained from each State. Basically, as noted in PM A-99-62, State-only operated programs that are not matched by Federal funds are not includable in Medicare DSH, while Title XIX programs, matched by Federal funds, are includable. Besler is requesting your State-specific information related to Medicaid eligibility codes, identifying Medicaid programs, the Medicaid payment code assigned to each program, and whether the specific program is federally matched.

I have also included an excerpt of 5 pages of the 41 pages of the Massachusetts codes/descriptions to demonstrate the information we are looking for. As noted, the list shows Aid Category, Category Description, as well as the Federal Funding percentage. As an example, Aid category 00- Refugee is not federally funded and therefore would not be includable in Medicare DSH. Similarly, Aid category 07- Disabled is federally funded at 50% and would be included.

3 Independence Way
Suite 201
Princeton, NJ 08540
phone 609.514.1400
fax 609.514.1410

32 Anna Street
Ocean Ridge, FL 33410
phone 561.622.9068
fax 609.514.1410

One Adams Place
859 Willard Street, Suite 400
Quincy, MA 02169
phone 781.353.6419
fax 781.353.6499

It is our understanding that in order to be compliant with Medicare regulations, a list of eligibility codes as described in this request must be maintained by each State. Please note that we are not requesting patient-specific information. Also, please provide codes and information that are current as of the date of your reply to this request.

Besler thanks you for your assistance and if you have any questions, please do not hesitate to contact me at 732-839-3894 or by e mail at gporette@besler.com.

Sincerely,

George Porette

George E. Porette
Manager, Financial Services

Program Memorandum
Intermediaries

Department of Health and Human Services (DHHS)
HEALTH CARE FINANCING ADMINISTRATION (HCFA)

Transmittal No. A-99-62 THIS IS THE FINAL Date: DECEMBER 1999

CHANGE REQUEST 1052

SUBJECT: Clarification of Allowable Medicaid Days in the Medicare Disproportionate Share Hospital (DSH) Adjustment Calculation--ACTION

A review of practices and policies regarding Medicare disproportionate share payment determination led HCFA to conclude that it is necessary to clarify the definition of eligible Medicaid days in Medicare disproportionate share policy and communicate this information to fiscal intermediaries, hospitals, Medicaid State agencies, and Medicaid managed care organizations. **This clarification applies to cost reporting periods beginning on or after January 1, 2000.** The purpose of this memorandum is to address those details that may need clarification and also to communicate the hold harmless position for cost reporting periods beginning before January 1, 2000. A similar memorandum will be sent to the Medicaid State agencies.

CLARIFICATION FOR COST REPORTING PERIODS BEGINNING ON OR AFTER JANUARY 1, 2000

Background

Under section 1886(d)(5)(F) of the Social Security Act, the Medicare disproportionate share patient percentage is made up of two computations. The first computation includes patient days that were furnished to patients who, during a given month, were entitled to both Medicare Part A and Supplemental Security Income (SSI) (excluding State supplementation). This number is divided by the number of covered patient days utilized by patients under Medicare Part A for that same period. The second computation includes patient days associated with beneficiaries who were eligible for medical assistance (Medicaid) under a State plan approved under Title XIX but who were not entitled to Medicare Part A. (See 42 CFR 412.106(b)(4).) This number is divided by the total number of patient days for that same period.

Included Days

In calculating the number of Medicaid days, the hospital must determine whether the patient was eligible for Medicaid under a State plan approved under Title XIX on the day of service. If the patient was so eligible, the day counts in the Medicare disproportionate share adjustment calculation. The statutory formula for "Medicaid days" reflects several key concepts. First, the focus is on the patient's eligibility for Medicaid benefits as determined by the State, not the hospital's "eligibility" for some form of Medicaid payment. Second, the focus is on the patient's eligibility for medical assistance under an approved Title XIX State plan, not the patient's eligibility for general assistance under a State-only program. Third, the focus is on eligibility for medical assistance under an approved Title XIX State plan, not medical assistance under a State-only program or other program. Thus, for a day to be counted, the patient must be eligible on that day for medical assistance benefits under the Federal-State cooperative program known as Medicaid (under an approved Title XIX State plan). In other words, for purposes of the Medicare disproportionate share adjustment

calculation, the term "Medicaid days" refers to days on which the patient is eligible for medical assistance benefits under an approved Title XIX State plan. The term "Medicaid days" does not refer to all days that have some relation to the Medicaid program, through a matching payment or otherwise; if a patient is not eligible for medical assistance benefits under an approved Title XIX State plan, the patient day cannot become a "Medicaid day" simply by virtue of some other association with the Medicaid program.

Medicaid days, for purposes of the Medicare disproportionate share adjustment calculation, include all days during which a patient is eligible, under a State plan approved under Title XIX, for Medicaid benefits, even if Medicaid did not make payment for any services. Thus, Medicaid days include, but are not limited to, days that are determined to be medically necessary but for which payment is denied by Medicaid because the provider did not bill timely, days that are beyond the number of days for which a State will pay, days that are utilized by a Medicaid beneficiary prior to an admission approval but for which a valid enrollment is determined within the prescribed period, and days for which payment is made by a third party. In addition, we recognize in the calculation days that are utilized by a Medicaid beneficiary who is eligible for Medicaid under a State plan approved under Title XIX through a managed care organization (MCO) or health maintenance organization (HMO). However, in accordance with 42 CFR 412.106(b)(4), a day does not count in the Medicare disproportionate share adjustment calculation if the patient was entitled to both Medicare Part A and Medicaid on that day. Therefore, once the eligibility of the patient for Medicaid under a State plan approved under Title XIX has been verified, you must determine whether any of the days are dual entitlement days and, to the extent that they are, subtract them from the other days in the calculation.

Excluded Days

Many States operate programs that include both State-only and Federal-State eligibility groups in an integrated program. For example, some States provide medical assistance to beneficiaries of State-funded income support programs. These beneficiaries, however, are not eligible for Medicaid under a State plan approved under Title XIX, and, therefore, days utilized by these beneficiaries do not count in the Medicare disproportionate share adjustment calculation. If a hospital is unable to distinguish between Medicaid beneficiaries and other medical assistance beneficiaries, then it must contact the State for assistance in doing so.

In addition, if a given patient day affects the level of Medicaid DSH payments to the hospital but the patient is not eligible for Medicaid under a State plan approved under Title XIX on that day, the day is not included in the Medicare DSH calculation.

It should be noted that the types of days discussed above are not necessarily the only types of excluded days. Please see the attached chart, which summarizes some, but not necessarily all, of the types of days to be excluded from (or included in) the Medicare DSH adjustment calculation.

To provide consistency in both components of the calculation, any days that are added to the Medicaid day count must also be added to the total day count, to the extent that they have not been previously so added.

Regardless of the type of allowable Medicaid day, the hospital bears the burden of proof and must verify with the State that the patient was eligible under one of the allowable categories during each day of the patient's stay. The hospital is responsible for and must provide adequate documentation to substantiate the number of Medicaid days claimed. Days for patients that cannot be verified by State records to have fallen within a period wherein the patient was eligible for Medicaid as described in this memorandum cannot be counted.

HOLD HARMLESS FOR COST REPORTING PERIODS BEGINNING BEFORE JANUARY 1, 2000

In accordance with the hold harmless position communicated by HCFA on October 15, 1999, for cost reporting periods beginning before January 1, 2000, you are not to disallow, within the parameters discussed below, the portion of Medicare DSH adjustment payments previously made to hospitals attributable to the erroneous inclusion of general assistance or other State-only health program, charity care, Medicaid DSH, and/or ineligible waiver or demonstration population days in the Medicaid days factor used in the Medicare DSH formula. This is consistent with HCFA's determination that hospitals and intermediaries relied, for the most part, on Medicaid days data obtained from State Medicaid agencies to compute Medicare DSH payments and that some of those agencies commingled the types of otherwise ineligible days listed above with Medicaid Title XIX days in the data transmitted to hospitals and/or intermediaries. Although HCFA has decided to allow the hospitals to be held harmless for receiving additional payments resulting from the erroneous inclusion of these types of otherwise ineligible days, this decision is not intended to hold hospitals harmless for any other aspect of the calculation of Medicare DSH payments or any other Medicare payments.

Hospitals That Received Payments Reflecting the Erroneous Inclusion of Days at Issue

In practical terms this means that you are not to reopen any cost reports for cost reporting periods beginning before January 1, 2000 to disallow the portions of Medicare DSH payments attributable to the erroneous inclusion of general assistance or other State-only health program, charity care, Medicaid DSH, and/or ineligible waiver or demonstration population days if the hospital received payments for those days based on those cost reports. If, prior to the issuance of this Program Memorandum, you reopened a settled cost report to disallow the portion of Medicare DSH payment attributable to the inclusion of these types of days, reopen that cost report again and refund the amounts (including interest) collected. Do not, however, pay the hospitals interest on the amounts previously recouped as result of the disallowance. Furthermore, on or after October 15, 1999, you are not to accept reopening requests for previously settled cost reports or amendments to previously submitted cost reports pertaining to the inclusion of these types of days in the Medicare DSH formula.

For cost reporting periods beginning before January 1, 2000, you are to continue to allow these types of days in the Medicare DSH calculation for all open cost reports only in accordance with the practice followed for the hospital at issue before October 15, 1999 (i.e., for open cost reports, you are to allow only those types of otherwise ineligible days that the hospital received payment for in previous cost reporting periods settled before October 15, 1999). For example, if, for a given hospital, a portion of Medicare DSH payment was attributable to the erroneous inclusion of general assistance days for only the out-of-State or HMO population in cost reports settled before October 15, 1999, you are to include the ineligible waiver days for only that population when settling open cost reports for cost reporting periods beginning before January 1, 2000. However, the actual number of general assistance and other State-only health program, charity care, Medicaid DSH, and/or ineligible waiver or demonstration days, as well as Medicaid Title XIX days, that you allow for the open cost reports must be supported by auditable documentation provided by the hospital.

Hospitals That Did Not Receive Payments Reflecting the Erroneous Inclusion of Days at Issue

If a hospital did not receive any payment based on the erroneous inclusion of general assistance or other State-only health program, charity care, Medicaid DSH, and/or waiver or demonstration population days for cost reports that were settled before October 15, 1999, and the hospital never filed a jurisdictionally proper appeal to the Provider Reimbursement Review Board (PRRB) on this issue, you are not to pay the hospital based on the inclusion of these types of days for any open cost

reports for cost reporting periods beginning before January 1, 2000. Furthermore, on or after October 15, 1999, you are not to accept reopening requests for previously settled cost reports or amendments to previously submitted cost reports pertaining to the inclusion of these types of days in the Medicare DSH formula.

If, for cost reporting periods beginning before January 1, 2000, a hospital that did not receive payments reflecting the erroneous inclusion of otherwise ineligible days filed a jurisdictionally proper appeal to the PRRB on the issue of the exclusion of these types of days from the Medicare DSH formula before October 15, 1999, reopen the cost report at issue and revise the Medicare DSH payment to reflect the inclusion of these types of days as Medicaid days. If there are any questions or concerns regarding the qualifications for a "jurisdictionally proper appeal", please submit them in writing before rendering a decision in a specific case to Charles Booth, Director, Financial Services Group, Office of Financial Management, 7500 Security Boulevard, Location C3-14-16, Baltimore, Maryland 21244-1850. Where, for cost reporting periods beginning before January 1, 2000, a hospital filed a jurisdictionally proper appeal to the PRRB on the issue of the exclusion of these types of days from the Medicare DSH formula on or after October 15, 1999, reopen the settled cost report at issue and revise the Medicare DSH payment to reflect the inclusion of these types of days as Medicaid days, but only if the hospital appealed, before October 15, 1999, the denial of payment for the days in question in previous cost reporting periods. The actual number of these types of days that you use in this revision must be properly supported by adequate documentation provided by the hospital. Do not reopen a cost report and revise the Medicare DSH payment to reflect the inclusion of these types of days as Medicaid days if, on or after October 15, 1999, a hospital added the issue of the exclusion of these types of days to a jurisdictionally proper appeal already pending before PRRB on other Medicare DSH issues or other unrelated issues.

You are to continue paying the Medicare DSH adjustment reflecting the inclusion of general assistance or other State-only health program, charity care, Medicaid DSH, and/or waiver or demonstration population days for all open cost reports for cost reporting periods beginning before January 1, 2000, to any hospital that, before October 15, 1999, filed a jurisdictionally proper appeal to the PRRB specifically for this issue on previously settled cost reports.

Finally, you are reminded that, if a hospital has filed a jurisdictionally proper appeal with respect to the HCFA 97-2 ruling and the hospital has otherwise received payment for the portion of Medicare DSH adjustment attributable to the inclusion of general assistance or other State-only health programs, charity care, Medicaid DSH, and/or ineligible waiver or demonstration population days based on its paid Medicaid days, include these types of unpaid days in the Medicare DSH formula when revising the cost reports affected by the HCFA 97-2 appeal.

The *effective date* for this Program Memorandum (PM) is for cost reporting periods beginning on or after January 1, 2000.

The *implementation date* for this PM is January 1, 2000.

Funding is available through a Supplemental Budget Request for costs required for implementation.

PM may be discarded after January 31, 2001.

SPECIAL INSTRUCTIONS TO THE INTERMEDIARIES FOR PUBLISHING THE PM: The intermediaries are required to distribute the content of this PM to all the hospitals immediately upon receipt of the PM.

Attachment

Attachment

TYPE OF DAY	DESCRIPTION	ELIGIBLE TITLE XIX DAY
General Assistance Patient Days	Days for patients covered under a State-only (or county-only) general assistance program (whether or not any payment is available for health care services under the program). These patients are not Medicaid-eligible under the State plan.	No
Other State-Only Health Program Patient Days	Days for patients covered under a State-only health program. These patients are not Medicaid-eligible under the State plan.	No
Charity Care Patient Days	Days for patients not eligible for Medicaid or any other third-party payer, and claimed as uncompensated care by a hospital. These patients are not Medicaid-eligible under the State plan.	No.
Actual 1902(r)(2) and 1931(b) Days	Days for patients eligible under a State plan based on a 1902(r)(2) or 1931(b) election. These patients are Medicaid-eligible under the Title XIX State plan under the authority of these provisions, which is exercised by the State in the context of the approved State plan.	Yes.
Medicaid Optional Targeted Low Income Children (CHIP-related) Days	Days for patients who are Title XIX-eligible and who meet the definition of "optional targeted low income children" under section 1905(u)(2). The difference between these children and other Title XIX children is the enhanced FMAP rate available to the State. These children are fully Medicaid-eligible under the State plan.	Yes.
Separate CHIP Days	Days for patients who are eligible for benefits under a non-Medicaid State program furnishing child health assistance to targeted low-income children. These children are, by definition, not Medicaid-eligible under a State plan.	No.
1915(c) Eligible Patient (the "217" group) Days	Days for patients in the eligibility group under the State plan for individuals under a Home and Community Based Services waiver. This group includes individuals who would be Medicaid-eligible if they were in a medical institution. Under this special eligibility group, they are Medicaid-eligible under the State plan.	Yes.
Retroactive Eligible Days	Days for patients not enrolled in the Medicaid program at the time of service, but found retroactively eligible for Medicaid benefits for the days at issue. These patients are Medicaid-eligible under the State plan.	Yes.
Medicaid Managed Care Organization Days	Days for patients who are eligible for Medicaid under a State plan when the payment to the hospital is made by an MCO for the service. An MCO is the financing mechanism for Medicaid benefits, and payment for the service through the MCO does not affect eligibility.	Yes.

Medicaid DSH Days	Days for patients who are not eligible for Medicaid benefits, but are considered in the calculation of Medicaid DSH payments by the State. These patients are not Medicaid-eligible. Sometimes Medicaid State plans specify that Medicaid DSH payments are based upon a hospital's amount of charity care or general assistance days. This, however, is not "payment" for those days, and does not mean that the patient is eligible for Medicaid benefits or can be counted as such in the Medicare formula.	No.

(Excerpt 5 pgs from 41 pg. listing)

AID CATEGORY / COVERAGE TYPE / WAIVER / FFP MATRIX

As of 04/29/08

Aid Category	Aid Category Description	Coverage Type	"Checks" (MA-21 criteria or expected referred criteria)	1115 WAIVER Flag	SCHIP Flag and SCHIP Type	If Waiver, Waiver Category	FFP Percentage By Waiver and SCHIP flag	Dual Flag
00	Refugee	Standard	Never Waiver	No	No	--	100% Refugee Program	Full
01	SSI Aged	Standard	Not on MA-21	No	No	--	Federal Funding @ 50%	Full
02	TAFDC	Standard	Not on MA-21	Yes	No	Base, Families • May include 65+ (if caretaker of child)	Federal Funding @ 50%	Full
03	SSI Disabled	Standard	Not on Ma-21	Yes	No	Base, Disabled	Federal Funding @ 50%	Full
04	EAEDC	EAEDC	Never Waiver	No	No	--	100% State Funding	State
05	MA Aged	Standard	Not on MA-21	No	No	--	Federal Funding @ 50% Aid 05 Open Actn Rsn 15 Aid 05 Open Actn Rsn 19	Full Partial Partial
06	MA TAFDC	Standard	Not on MA-21	Yes	No	Base, Families • May include 65+ (if caretaker of child)	Federal Funding @ 50%	Full
07	MA Disabled	Standard	Not on MA-21	Yes	No	Base, Disabled	Federal Funding @ 50% Aid 07 Open Actn Rsn 15 Aid 07 Open Actn Rsn 19	Full Partial Partial
08	MA Multi Assistance Unit (DSS/DYS)	Standard	Not on MA-21	Yes	No	Base, Families	Federal Funding @ 50%	Full
10 Assigned by Claims (Aid 06 and Open Actn Rsn 06)	CH Basic (end 1989)	Common Health	Not on MA-21 DOS<7/1/97	No	No	--	State Funded if DOS< 7/1/97 Federal Funded @50% if DOS>= 7/1/97 *Up until 7/1/05 some coded as XIXE SCHIP*	Full
11 Assigned by Claims (Aid 06 and Open Actn Rsn 07)	CH Disabled Working Adult	Common Health	Not on MA-21 DOS<7/1/97	No	No	--	State Funded if DOS< 7/1/97 Federal Funded @ 50% if DOS>= 7/1/97 *Up until 7/1/05 some coded as XIXE SCHIP*	Full
12 Assigned by Claims (Aid 06 and Open Actn Rsn 08)	CH Disabled Child	Common Health	Not on MA-21 DOS<7/1/97	Yes if FPL>200%	No	1115 Waiver Expansion, CommonHealth • FPL>200%	State Funded if DOS< 7/1/97 Federal Funded @ 50% if DOS>= 7/1/97 *Up until 7/1/05 some coded as XIXE SCHIP*	Full

Aid Category	Aid Category Description	Coverage Type	"Checks" (MA-21 criteria or expected referred criteria)	1115 WAIVER Flag	SCHIP Flag and SCHIP Type	If Waiver, Waiver Category	FFP Percentage By Waiver and SCHIP flag	Dual Flag
13 Assigned by Claims (Aid 06 and Open Actn Rsn 16) (end 1989)	CH Plus	Common Health	Not on MA-21 DOS<7/1/97	No	No	–	State Funded if DOS< 7/1/97 Federal Funded @ 50% if DOS>= 7/1/97 *Up until 7/1/05 some coded as XIXE SCHIP*	Full
14	MCB SSI	Standard	Not on MA-21	Yes	No	Base, Disabled	Federal Funding @ 50%	Full
15	MCB MA	Standard		Yes	No	Base, MCB	Federal Funding @ 50% Aid 15 Open Actn Rsn 15 Aid 15 Open Actn Rsn 19	Full Partial Partial
16 Assigned by Claims (Aid 15 and Open Actn Rsn 44)	SF - MCB	Standard	Not on MA-21	Yes	No	Base, MCB	ESO 50% Federal Funding All Others 100% State Fundng	State
17 Assigned by Claims (Aid 15 and Open Actn Rsn 12)	MCB MA with QMB	Standard + Medicare Premium Payment (Coinsur and Deductble)	Not on MA-21	Yes	No	Base, MCB	Federal Funding @ 50%	Full
18 (Effective 8/31/00)	TMA Disabled QMB Parents	Standard & Medicare Premium Payment (Coinsur and Deductble)	Not on MA-21	Yes	No	Base, Families • May include 65+ (if caretaker of child)	Federal Funding @ 50%	Full
19 Assigned by Claims (Aid 15 and Open Actn Rsn 15)	MCB MA QMB Only	Senior Buy In	Not on MA-21	Yes	No	Base, MCB	Federal Funding @ 50%	Partial
20 Assigned by Claims (Aid 05 and Open Actn Rsn 12)	MA Aged with QMB (20 along with aid 05 & rsn 12 sent by MA21)	Standard + Medicare Premium Payment (Coinsur and Deductble)	Not on MA-21	No	No	--	Federal Funding @ 50%	Full

Aid Category	Aid Category Description	Coverage Type	"Checks" (MA-21 criteria or expected referred criteria)	1115 WAIVER Flag	SCHIP Flag and SCHIP Type	If Waiver, Waiver Category	FFP Percentage By Waiver and SCHIP flag	Dual Flag
21 Assigned by Claims (Aid 07 and Open Actn Rsn 12)	MA Disabled with QMB (21 along with aid 05 & rsn 12 sent by MA21)	Standard + Medicare Premium Payment (Coinsur and Deductble)	Not on MA-21	Yes	No	Base, Disabled	Federal Funding @ 50%	Full
22 Assigned by Claims (Aid 05 and Open Actn Rsn 15)	MA Aged QMB Only (22 along with aid 05 & rsn 15 sent by MA21)	Senior Buy In	Not on MA-21 Age>=65	No	No	--	Federal Funding @ 50%	Partial
23 Assigned by Claims (Aid 07 and Open Actn Rsn 5)	MA Disabled QMB Only (23 along with aid 07 & rsn 15 sent by MA21)	Senior Buy In	Not on MA-21	Yes	No	Base, Disabled	Federal Funding @ 50%	Partial
24 Assigned by Claims (Aid 05 and Open Actn Rsn 19)	MA Aged SLMB Only	Buy In	Age >=65	No	No	--	Federal Funding @ 50%	Partial
25 Assigned by Claims (Aid 07 and Open Actn Rsn 19)	MA Disabled SLMB Only	Buy In		Yes	No	Base, Disabled	Federal Funding @ 50%	Partial
26 Assigned by MARS (Aid 08 and Case ID begins w/ith X)	DSS	Standard		Yes	No	Base, Families	Federal Funding @ 50%	Full
27 Assigned by MARS (Aid 08 and Case ID begins with 990)	DYS	Standard		Yes	No	Base, Families	Federal Funding @ 50%	Full

Aid Category	Aid Category Description	Coverage Type	"Checks" (MA-21 criteria or expected referred criteria)	1115 WAIVER Flag	SCHIP Flag and SCHIP Type	If Waiver, Waiver Category	FFP Percentage By Waiver and SCHIP flag	Dual Flag
28 Assigned by MARS (Aid 00 and Actn Rsn 02, 06, 08, 14, 16, 18, 82)	Categorically Refugee	Standard	Not MA-21 Never Waiver	No	No	--	100% Refugee Program	Full
29 Assigned by MARS (Aid 00 and Open Actn Rsn 07, 09, 15, 17)	Non Categorically Refugee	Standard	Not MA-21 Never Waiver	No	No	--	100% Refugee Program	Full
30 Assigned by Claims	MCO Extended Coverage - Medicaid	Standard		Yes	Yes for some		(Aid cats 30,40,EA,EB,EE, EF,EK are reported the same)	Full
30	<1	Standard	• Mother on Medicaid at time of child's birth OR • FPL<=185%	Yes	Yes, XIXE If: • FPL >185% • No TPL at time of application • Mother not on Medicaid at time of child's birth	Base, Families • FPL<=185% OR • Mother was on Medicaid at time of child's birth 1902(R)2, Children • FPL >185% • Mother not on Medicaid at time of child's birth	SCHIP: Federal Funding @ 65% All other: Federal Funding @ 50%	
30	Age 1-5	Standard	• FPL<=133%	Yes	Yes, XIXE if: • FPL>133% • No TPL at time of application	Base, Families • FPL<=133% 1902(R)2, Children • FPL >133%	SCHIP: Federal Funding @ 65% All other: Federal Funding @ 50%	
30	Age 6-14 and not pregnant	Standard	• DOB>=9/30/83 • FPL<=114% OR • DOB<9/30/83 • FPL<=86%	Yes	Yes, XIXE if • DOB>=9/30/83 • FPL > 113% • No TPL at time of application	Base, Families • FPL<=133% 1902(R)2, Children • FPL >133%	SCHIP: Federal Funding @ 65% All other: Federal Funding @ 50%	

Aid Category	Aid Category Description	Coverage Type	"Checks" (MA-21 criteria or expected referred criteria)	1115 WAIVER Flag	SCHIP Flag and SCHIP Type	If Waiver, Waiver Category	FFP Percentage By Waiver and SCHIP flag	Dual Flag
30	Age 14-17 and not pregnant	Standard	• DOB>=9/30/83 • FPL<=114% OR • DOB<9/30/83 • FPL<=86%	Yes	Yes, XIXE if: • DOB<9/30/83 • No TPL at time of application • FPL >86% OR • DOB>=9/30/83 • FPL >113% • No TPL at time of application	Base, Families • FPL<=133% 1902(R)2, Children • FPL >133%	SCHIP: Federal Funding @ 65% All other: Federal Funding @ 50%	
30	Pregnant	Standard	• Age 19+ • FPL<=133% OR • Age <19 • FPL<=200%	Yes	Yes, XIXE if: • FPL>185% • No TPL at time of application • Age <=18	Base, Families • FPL <= 185% 1902(R)2, Children • FPL>185%	SCHIP: Federal Funding @ 65% All other: Federal Funding @ 50%	
30	18+ and not pregnant	Standard	• FPL <=133%	Yes	No	If MA21 Disbld = BL,DA,MA & FPL<=133% Base, Disabled Otherwise If FPL<=133% Base, Families • May include 65+ (if caretaker of child)	Federal Funding @ 50%	
31 Assigned by Claims	MCO Extended Coverage - CH	Common Health	Not MA-21 Effective 7/1/97	Yes	No	If DOS >= 7/1/97 1115 Waiver Expansion, Common Health	State Funded if DOS< 7/1/97 Federal Funded @ 50% If DOS>= 7/1/97	Full
32 Assigned by MARS (Aid 00 and Open Actn Rsn 03)	Other Refugee	Standard	Not MA-21	No	No	Base, Families • May include 65+ (if caretaker of child)	100% Refugee Program	Full
33 Assigned by MARS (Aid 00 and Open Actn Rsn 60, 61, 65, 68, 74)	Refugee TMA	Standard	Not MA-21 Never Waiver	No	No	–	100% Refugee Program	Full
34 Assigned by MARS (Aid 02 and Open Actn Rsn 60, 61, 65, 68, 74)	TAFDC TMA	Standard	Not MA-21	Yes	No	Base, Families • May include 65+ (if caretaker of child)	Federal Funding @ 50%	Full

TO:

FROM:

SUBJECT: Cost of Processing FOIA Request #

The South Carolina Department of Health and Human Services has received and processed your FOIA request. The cost for processing this information is as follows:

Staff processing time at $10.00 per hour	_____ Hours	$_____
Pages copied at $.10 per page	_____ Pages	$_____
Pages faxed at $.20 per page	_____ Pages	$_____
Shipping and Handling Costs		$_____
Other costs associated with the FOIA request: _____		$_____
Total Amount Due SCDHHS:		$_____

Please remit the above amount to the following address:

Bureau of Fiscal Affairs
South Carolina Department of Health and Human Services
Post Office Box 8297
Columbia, South Carolina 29202-8297

Please contact _____ should you have any questions.

_____ _____
Signature Date:

Brenda James - Fwd: Re: Log 299 FOIA

From: Teeshla Curtis
To: Brenda James
Date: 02/15/2012 8:33 AM
Subject: Fwd: Re: Log 299 FOIA

>>> Rick Hepfer 2/14/2012 6:27 PM >>>
A response to this FOIA is, by statute, due by February 22nd. If by "extension" you mean pushing the statutory time back, you cannot get that kind of extension. However, if you cannot gather the information by that time, we can meet the statutory deadline by writing the requester, usually on the progress and estimate the time it will take to finish. Let me know if you have questions. If you tell me a little about the information you think will be responsive, I can suggest some language. I couldn't tell where these folks are coming from or what in the world they are talking about, until I did a little research. So, I have some information if you need it. 8-2791.

>>> Teeshla Curtis 2/14/2012 5:07 PM >>>
Rick,

This is a FOIA request dated February 1. Would you be able to call Mr. Porette to let him know we are working on his request? See attached Log Letter.

Thank you,

Teeshla

>>> Michael Jones 2/14/2012 4:59 PM >>>
Can we get an extension on this one?

-----Original Message-----
From: Teeshla Curtis
Cc: Rick Hepfer <Hepfer@scdhhs.gov>
To: Michael Jones <JONEST@scdhhs.gov>
Cc: Jennifer McNeil <MCNEILJ@scdhhs.gov>

Sent: 2/14/2012 4:58:11 PM
Subject: Re: Log 299 FOIA

Michael,

Just following up on this FOIA request.
Teeshla

>>> Teeshla Curtis 2/3/2012 11:15 AM >>>
Michael,

Attached is log 299 due 2.13.12. This FOIA request started in Jeff Saxon's area and they decided it was an eligibility issue.

I am copying Rick Hepfer so he can review the request.

Thanks,
Teeshla

Brenda James - Log 299

From: Teeshla Curtis
To: Brenda James
Date: 03/01/2012 10:55 AM
Subject: Log 299
CC: Michael Jones; Sharon Mondier
Attachments: Ref Log 000299 Response.PDF

Brenda,

Attached is the response for Log 299.

Teeshla

South Carolina Department of Health & Human Services

Anthony E. Keck, Director
Nikki R. Haley, Governor

February 24, 2012

Mr. George E. Porette
Manager, Financial Services
Besler Consulting
3 Independence Way, Suite 201
Princeton, New Jersey 08540

Dear Mr. Porette:

In response to your Freedom of Information Act (FOIA) request, enclosed is a report that contains South Carolina specific information related to the following: Medicaid eligibility codes, identifying Medicaid programs, the Medicaid payment code assigned to each program, and whether the specific program is federally matched.

Also enclosed is a detailed list of the costs associated with processing your FOIA request. Our expense for collecting the data is $40. Please remit the payment as soon as possible.

If you have any questions, please contact Michael Jones at (803) 898-2987.

Sincerely,

John R. Supra, Jr.
Deputy Director

JS/tc
Enclosures

cc: Lynette Wilson, Receivables

Office of Information Management
P.O. Box 8206 • Columbia, South Carolina 29202-8206
(803) 898-2502 • Fax (803) 898-8235

TO: Mr. George E. Porette
Manager, Financial Services
Besler Consulting

FROM: John R. Supra, Jr.
Deputy Director

SUBJECT: Cost of Processing FOIA Request

The South Carolina Department of Health and Human Services has received and processed your FOIA request. The cost for processing this information is as follows:

Staff processing time at $10.00 per hour	4 Hour	$40.00
Pages copied at $.10 per page	_____ Pages	$____
Pages faxed at $.20 per page	_____ Pages	$____
Shipping and Handling Costs		$____
Other costs associated with the FOIA request: _____		$____
Total Amount Due SCDHHS:		**$40.00**

Please remit the above amount to the following address:

Bureau of Fiscal Affairs
South Carolina Department of Health and Human Services
Post Office Box 8297
Columbia, South Carolina 29202-8297

Please contact Michael Jones (803) 898-2987 should you have any questions.

Signature

February 24, 2012
Date

No. 1158- 07357

SOUTH CAROLINA
STATE HEALTH AND HUMAN SERVICES
FINANCE COMMISSION

ACCOUNTS RECEIVABLE CERTIFICATION

RECEIVABLE NUMBER:

GENERAL INFORMATION

CERTIFICATION ACTION: [XX] NEW [ ] CHANGE

DEBT CLASSIFICATION: [ ] FRAUD [ ] NON-FRAUD

NAME OF DEBTOR:
Mr. George E. Porette
Manager, Financial Services, Besler Consulting

COUNTY NAME:

ADDRESS OF DEBTOR:
3 Independence Way, Suite 201
Princeton, New Jersey 08540

COUNTY NUMBER:

PROVIDER ID NUMBER OR FAMILY CASE NUMBER:

PERIOD OF OVERPAYMENT

FROM:

TO:

PROGRAM INVOLVED:	TYPE SERVICE:	AMOUNT DUE:	DATE DUE:
	FOIA Log #299	$40.00	

FUNDING INFORMATION

	AMOUNT	COST CENTER		AMOUNT	COST CENTER
STATE	$		DONOR	$	
FEDERAL	$		PROVIDER	$	
COUNTY	$		OTHER	$	
			PENALTY	$	

PAYMENT INFORMATION

[ ] DEDUCT [ ] DO NOT DEDUCT

REPAYMENT TERMS

TERMS GRANTED (Months):

INTEREST RATE:

NOTES — LIST OF ATTACHMENTS

REQUESTER'S SIGNATURE:	TITLE:	COUNTY/DIVISION:	DATE:
Teeshla Curtis	Admin Coordinator		2/24/12
AUTHORIZER'S SIGNATURE:	TITLE:	COUNTY/DIVISION:	DATE:
John Supra	Deputy Director		2/24/12

HHSFC 1158 (Aug 88)

South Carolina Medicaid Programs

Payment Category	Program	Eligible Population	Benefits	State Match	Federal Match
32	ABD - Aged, Blind, or Disabled	ABD - Aged (65+), blind or totally and permanently disabled	Medicaid Benefits	29.76%	70.24%
15	HCBS - Home and Community Based (Waivered) Services *Includes DDSN & AIDS waivered services*	Aged, blind or disabled and determined to be medically in need of institutional care but chooses to remain at home - Must require/receive at least one waivered service for a minimum of 30 consecutive days	Medicaid Card and Medicaid sponsored vendor payment - Inviduals are required to pay a part of the cost of care	29.76%	70.24%
10, 14, 15, 54	MAO – Institutional Long-Term Care	Aged, blind or disabled and determined to be medically in need of institutional care and reside in an approved medical facility for at least 30 consecutive days	Medicaid Card and Medicaid sponsored vendor payment - Inviduals are required to pay a part of the cost of care	29.76%	70.24%
85, 86	OSS - Optional State Supplementation	Individuals residing in approved, licensed Residential Care Homes who meet SSI eligibility requirements, except for income	State-funded cash assistance payment plus Medicaid benefits	100%	0%
50	QDWI - Qualified Disabled Working Individuals	Disabled individuals who lost eligibility for Title II benefits and Social Security support of Medicare premiums because of wages	Payment of monthly Medicare Part A premiums only - NO Medicaid Card	29.76%	70.24%
52	SLMB - Special Low Income Medicare Beneficiaries	Must have Medicare Part A benefits	Medicare Part B premiums only - NO Medicaid Card	29.76%	70.24%
48	QI - Qualifying Individual	Must have Medicare Part A benefits	Medicare Part B-premiums only- NO Medicaid Card	0%	100%
16	SSI Pass-Along	Individuals who lost eligibility for SSI due to increases in or receipt of certain Social Security benefits	Medicaid benefits	29.76%	70.24%
80	SSI - Supplemental Security Income Administered by SSA	Aged (65+), blind or totally and permanently disabled	A cash payment individual with no income receives $698 per month Medicaid benefits	29.76%	70.24%

South Carolina Medicaid Programs

Payment Category	Program	Eligible Population	Benefits	State Match	Federal Match
57	**TEFRA - Katie Beckett Children**	Disabled children under age 19 who meet level of care required in ICF-MR facility, nursing facility or hospital	Medicaid benefits	29.76%	70.24%
40	**WD** - Working Disabled	Under age 65, totally and permanently disabled and working	Medicaid benefits	29.76%	70.24%
71	**BCCP** - Breast and Cervical Cancer Program	Individuals who have been diagnosed and in need of treatment for breast or cervical cancer or pre-cancerous lesions (CIN II/III) and have no treatment coverage	Medicaid benefits	20.83%	79.17%
13, 60	**Foster Children** Includes certain special needs children in adoptive placement	Children under 21 years of age who reside in licensed foster homes or private child care facilities supported in whole or in part by state or federal foster care board payments	Medicaid benefits Certain categories of children may also receive a cash payment	29.76%	70.24%
31, 51	**IV-E Foster Care**	To qualify under this category, a Title IV-E Foster Care Maintenance payment must be made for the individual	Medicaid Benefits	29.76%	70.24%
11	**Four-Month Extended Medicaid**	Individuals who lost eligibility for Family Independence (FI) cash assistance due to an increase in child support	Medicaid benefits for up to 4 months beginning with the month of FI Ineligibility	29.76%	70.24%
88 (Medicaid)	**PHC** - Partners for Healthy Children	Low-income children up to age 19 if their family income is at or below 200% of federal poverty level	Medicaid benefits for the qualifying children	29.76%	70.24%
88 (CHIP)	**PHC** - Partners for Healthy Children	PHC-Eligible Children that also meet the CHIP Financial and Age Requirements for Enhanced Funding	Medicaid benefits for the qualifying children	20.83%	79.17%
59	**LIF** - Low Income Families	Low income families with children under 18 years of age or under 19 years of age, if attending a secondary school full-time	Medicaid benefits	29.76%	70.24%

South Carolina Medicaid Programs

Payment Category	Program	Eligible Population	Benefits	State Match	Federal Match
87	**OCWI - Optional Coverage for (Pregant) Women and Infants**	Pregnant women and infants under age 1 *Note: **Deemed infants - Infants born to a Medicaid eligible** mother - no application required Others - application required*	Medicaid coverage for the pregnant woman for the duration of the pregnancy	29.76%	70.24%
12	**OCWI** - Children Under Age 1	See above.	Medicaid coverage for any child under age 1	29.76%	70.24%
11	**TM** - Transitional Medicaid	Individuals who lost eligibility for LIF because of the earned income of the parent/caretaker(s) or loss of the earned income disregard (50%)	Medicaid benefits for up to 2 years beginning with the month of LIF inelibility	29.76%	70.24%
55	**FP** - Family Planning	Individuals (men and women) of any age are eligible if their income is at or below 185% of federal poverty level	Family Planning Services	10%	90%
91	**Ribicoff**	To qualify for this category, child must be under 18 years old (under 19 if a full-time student)	Medicaid Benefits	29.76%	70.24%