DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Bowling	3-12-07

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 000587	[X] Prepare reply for the Director's signature DATE DUE 3-19-07
2. DATE SIGNED BY DIRECTOR cc: Wells Cleared 10/5/07 Letter attached.	[ ] Prepare reply for appropriate signature DATE DUE [ ] FOIA DATE DUE [ ] Necessary Action

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
1.			
2.			
3.			
4.			

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

Log-Bowling
"Robly's Sign"
CC: Wells

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

March 8, 2007

RECEIVED
MAR 12 2007
Department of Health & Human Services
OFFICE OF THE DIRECTOR

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

Dear Mr. Kerr:

We have completed our review of **State Plan Amendment Transmittal (SPA) SC 06-014** which seeks to add medical social services as a covered service under the home health benefit. We have discussed the pending SPA with your staff from the Department of Health and Human Services. We find it is not approvable as submitted. Please provide the information requested below.

CMS advised the State that medical social services are not a component under the home health benefit. However, we also advised the State that it could be covered under the Other Licensed Practitioner's section (3.1-A, Item 6.d.) of the State Plan using an authority of 42 CFR 440.60.

The Centers for Medicare & Medicaid Services (CMS) now requires more detail in the descriptions of both services and payment methodology. All services on the same page(s) as the proposed changes covered in the SPA must meet the requirements specified below. Federal regulations at § 430.10 describe the State plan as:

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

Each service in Attachment 3.1-A should have a meaningful short description of the service, the service requirements and the limitations, the provider types and qualifications, and a corresponding clear description of the payment methodology in Attachment 4.19-B. It may be helpful to the State to remember that the following information must be provided:

1. Services
   There must be a meaningful description of each service (§1905(a) of the Act). This description must include who (the provider), what (an explanation of the service), where (the permissible locations for the provision of the service), and any limitations or restrictions placed on the services.

2. Providers –
Section 1902(a)(23) of the Act requires that beneficiaries obtain services from any qualified Medicaid provider that undertakes to provide them. We ask that State officials provide us with detailed information regarding how beneficiaries will receive freedom of choice of provider. Describe what "reasonable" qualifications are placed on providers. Providers must meet he same minimum qualifications regardless of the service site.

3. General Requirements –
The requirements for the services to be statewide, comparable in amount, duration and scope, statewideness, comparability, freedom of choices of providers, eligible providers, and direct payment to providers,

4. Payment –
For each service detailed in the coverage section of the State Plan (Attachment 3.1), there must be a corresponding payment methodology in attachment 4.19-B. The payment methodology as described on page 3 of Attachment 4.19-B of the State Plan is inappropriate in that the State has informed CMS of their intention to remove the service and payment from the Home Health Services section as was originally proposed by the State. Please provide a new methodology under other licensed practitioners to reimburse for medical social services.

5. In regards to the new methodology as requested in item 4 above and to the extent that governmental and non-governmental providers are reimbursed the same, the state should add the following to the body of the State Plan language, "Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of _____specify service) and the fee schedule and any annual/periodic adjustments to the schedule are published in _____(specify where published)."

In addition to the above requirements for all services, the State failed to answer the following written questions sent to the State on January 22, 2007. Please provide written answers to these questions.

1. Page 4a, Attachment 3.1-A, Item 6.d, Psychologists – We would like for the State to include the provider qualifications for the Counselors and School Psychologists.

2. Page 4a, Attachment 3.1-A, Item 7., Home Health Care Services - There is no "homebound" requirement in Medicaid home health, so we would like the State to remove the language and reference from the State Plan. Also, we'll need some assurance that the 75 visits per year are enough to meet the needs of those individuals requiring home health services. This assurance can be provided via e-mail rather than stated in the State Plan.

3. Page 5, Attachment 3.1-A, Item d., Physical Therapy (PT), Occupational Therapy (OT), Speech Pathology (SP), and Audiology Services. – For PT, OT, and SP services, we would like for the State to add language that these services are provided in accordance with provider qualification requirements found in 42 CFR 440.110. For audiology services, we would like for the State to add language that says all Medicaid-qualified audiology providers operating in the State of South Carolina adhere to the provider qualifications found in 42 CFR 440.110(c).

4. Page 4, Attachment 3.1-A, Items 6a.,6b., & 6c. Podiatrist, Optometrist, Chiropractors – While the State didn't submit this page, it must be brought into the SPA because of "same page issues" through the 4.19-B page that was submitted. We would like for the State to add the language found in 42 CFR 440.060 to the effect that these providers are licensed practitioners and that they are acting within the scope of practice as defined under State law.

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 on this request for additional information please contact Elaine Elmore on programmatic issues or Jay Gavens on fiscal issues. Ms Elmore can be reached at (404) 562-7408 and Mr. Gavens at (404) 562-7430. This written request for additional information stops the 90-day clock for the approval process on this SPA, which would have expired on March 13, 2007. Further, in accordance with the CMS guidelines to All State Medicaid Directors dated January 2, 2001, we request that you provide a formal response to this request for additional information no later than 90 days from the date of this letter. If you do not provide us with a formal response by that date, we will conclude that the State has not established that the proposed SPA is consistent with all statutory and regulatory requirements. Accordingly, at that time, we will initiate disapproval action on the amendment. In addition, because this SPA was submitted after January 2, 2001, and is effective on or after January 1, 2001, please be advised that we will defer any FFP that you claim for payments made in accordance with this proposed

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

Sincerely,

Renard L. Murray

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

Log-587

State of South Carolina
Department of Health and Human Services

Mark Sanford
Governor

Emma Forkner
Director

October 5, 2007

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

RE: South Carolina Title XIX State Plan Amendment SC 06-014

Dear Mr. Gavens:

The South Carolina Department of Health and Human Services (SCDHHS) is submitting revised plan language applicable to Attachments 3.1-A and 4.19-B that relate to the subject plan amendment. This revised plan language addresses each of the questions raised by Centers for Medicare and Medicaid Services (CMS) in the letter from you dated March 8, 2007.

In addition to this revised plan language, we are including the plan program description for medical social services that was requested in your previous correspondence. This includes the service description and provider qualifications for medical social services as necessary care provided by licensed practitioners as found in CFR 440.60.

SCDHHS proposes a service description for medical social services as follows:

> Under the direction of a plan of care which has been signed by a physician, qualified medical social services may be provided to Medicaid home health recipients, in their location, under the direct care of a Medicare certified home health agency contracted with the State Medicaid agency.
>
> Specific services necessitate the skills and capabilities of a qualified medical social worker to be performed safely and effectively. Medical social service functions must be provided by a social worker with a graduate degree from an accredited school of social work. All practitioners must be licensed or certified in accordance with federal and state requirements; be supervised by the clinical director of the home health agency; meet all requirements found in CFR 440.60, and be employed by a Medicare certified home health agency that is contracted with SCDHHS to provide services.

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(803) 898-2504 • Fax (803) 255-8235

Services provided must be identified during an assessment process of the social, emotional, and environmental issues and focused on the medical condition or the rate of recovery of the patient. The assessment must also include the relationship of the patient's medical and nursing requirements to the patient's home situation, financial resources and availability of community resources.

The medical social services staff identifies and obtains referrals to community resources on behalf of the patient; advocates through consultation, liaison, and interdisciplinary collaboration for the services for the patient, whose risk status may interfere with the achievement of the home health goals; and interface with the resolution of identified patient problems that cannot be resolved.

A continuous evaluation process is implemented to assess the achievement of specified goals and to address the impact on the patient's illness, need for care, response to treatment, and adjustment to care.

Medical social services furnished to the patient's family member or caregiver on a short-term basis when the home health agency can demonstrate that a brief intervention (that is two or three visits) by a medical social worker is necessary to remove a clean and direct impediment to the effective treatment of the patient's medical condition or to his or her rate of recovery. To be considered "clear and direct," the behavior or actions of the family member must plainly obstruct, contravene, or prevent the patient's medical treatment or rate of recovery. Medical social services to address general problems that do not clearly and directly impede treatment or recovery as well as long-term social services furnished to family members, such as ongoing alcohol counseling, are not covered.

CMS Question # 1:

Page 4a, Attachment 3.1-A, Item 6.d, Psychologists – We would like for the State to include the provider qualifications for the Counselors and School Psychologists.

SCDHHS Response:

The State has modified their language in the SPA to clarify this issue.

CMS Question # 2:

Page 4a, Attachment 3.1-A, Item 7., Home Health Care Services - There is no "homebound" requirement in Medicaid home health, so we would like the State to remove the language and reference from the State Plan. Also, we'll need some assurance that the 75 visits per year are enough to meet the needs of those individuals requiring home health services. This assurance can be provided via e-mail rather than stated in the State Plan.

SCDHHS Response:

The "homebound" language and reference in the State Pan will be removed.

An analysis of SFY2006 visits utilization for home health recipients indicate that the average number of visits per recipient was 16.5. The number of recipients utilizing the home health benefit was 6, 377 and the total number of home health visits for those recipients was 104,706. We believe that the 75-visit limitation has little impact on the services provided to the recipients.

CMS Question # 3:

Page 5, Attachment 3.1-A, Item d., Physical Therapy (PT), Occupational Therapy (OT), Speech Pathology (SP), and Audiology Services. – For PT, OT, and SP services, we would like for the State to add language that these services are provided in accordance with provider qualification requirements found in 42 CFR 440.110. For audiology services, we would like for the State to add language that says all Medicaid-qualified audiology providers operating in the State of South Carolina adhere to the provider qualifications found in 42 CFR 440.110(c).

SCDHHS Response:

For Physical Therapy, Occupational Therapy, and Speech Therapy, the State will include language that these services are provided in accordance with provider qualification requirements found in 42 CFR 440.110. The state will include language that indicates that all Medicaid qualified audiology providers operating in the state of South Carolina adhere to the provider qualifications found in 42 CFR 440.110(c).

CMS Question #4:

Page 4, Attachment 3.1-A, Items 6a., 6b., & 6c.; Podiatrist, Optometrist, Chiropractors – While the State didn't submit this page, it must be brought into the SPA because of "same page issues" through the 4.19-B page that was submitted. We would like for the State to add the language found in 42 CFR 440.60 to the effect that these providers are licensed practitioners and that they are acting within the scope of practice as defined under State law.

SCDHHS Response:

For each Provider listed in Items 6a, 6b. and 6c., the state will include language to the effect that these providers are licensed practitioners and that they are acting within the scope of practice as found in 440.60.

For clarification, we did not insert the suggested language referenced in your March 8, 2007 letter (page 2, section 5) in the revised SPA page 3, Attachment 4.19-B. The reimbursement methodology for governmental and private providers of medical social services is the same as is funding for the non-federal share (i.e. SCDHHS appropriations). However, as a review of the methodology for these services will reveal, the resulting payment per provider is facility specific and is not a universal or industry wide fee for service.

Responses to the standard funding questions are addressed below:

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

SCDHHS Response:

All Medicaid providers reimbursed for the services addressed in State Plan SC 06-014 retain one hundred percent of the Medicaid payments, per claim and supplemental, that they receive.

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 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) he 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
Laboratory Services	SCDHHS State Appropriations
End Stage Renal Disease Services	SCDHHS State Appropriations
Other Medical Professionals: Podiatrists Optometrists Chiropractors CRNA (Cert Registered Nurse Anesth) Nurse Practitioners Licensed Midwives Medical Social Services	SCDHHS State Appropriations
Other Medical Professionals: Psychologists	State Agency Appropriations - IGT
Home Health Agencies	SCDHHS State Appropriations

The state share for all services noted above are funded through state appropriations allocated directly to SCDHHS in the annual state appropriations act with the exception of payments to private psychologists. The state funds for these psychologists services are provided through Memorandums of Agreement with other state agencies who provide state appropriated funds via IGT. A schedule indicating the state agencies and IGT amounts for SFY 2007 is attached.

A schedule detailing an estimate of total expenditures and state share amounts for each type of payment reflected above under 4.19-B is enclosed.

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

SCDHHS Response:

Supplemental payments that are actually retrospective cost settlements are made to impacted Home Health providers and providers of medical social services. Please see the attached schedule referenced in response #2 for the amounts estimating supplemental payments that will be paid to these providers.

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

SCDHHS Response:

Public providers of home health services and medical social services are subject to retrospective cost settlements (subject to service rate caps). In the event that a public provider of home health services or medical social services is overpaid as a result of our review of the provider's cost report in accordance with our state plan payment methodology, the SCDHHS will recoup the excess and return the Federal share of the excess to CMS.

In regards to all other services identified in this plan amendment, the payment of a percentage of the Medicare/commercial rate or up to 100% of the Medicare rate is consistent with what the market pays for these services and therefore it does not exceed the reasonable costs of providing the services.

It is anticipated that the information provided will result in the approval of SPA SC-06-014. If you or your staff should have any questions please contact Anita Bowen at (803) 898-2697 or Jeff Saxon at (803) 898-1023.

Sincerely,

Emma Forkner
Director

EF/mwbh

Enclosures