DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

SPA # 11-014

TO	DATE
Singleton	10-19-11

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 11-169	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR cc: Mr. Keck, Deps, CMS file, Williams, Sayon/Hutto Cleared 11/16/11, letter attached	[X] Prepare reply for appropriate signature DATE DUE 11-24-11 [ ] 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.			

DEPA RTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
61 Forsyth Street, Suite 4T20
Atlanta, Georgia 30303

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

October 7, 2011

Mr. Anthony E. Keck
Director
Department of Health and Human Services
P.O. Box 8206
Columbia, South Carolina 29202-8206

RE: State Plan Amendment (SPA) 11-014

Dear Mr. Keck:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 11-014. Effective July 11, 2011 this amendment proposes to revise the inpatient hospital reimbursement methodology for determining payment rates. Specifically, the following changes are being proposed: reduce the inpatient per discharge and per diems rates to 93% of the October 1, 2010 rates except for state owned and operated hospitals; retrospective cost settlements for qualifying hospitals will be reduced to 93% of allowable Medicaid reimbursable cost; reduce South Carolina teaching hospitals graduate medical education cost by an additional 10% and discontinue payment to state border hospitals for graduate medical education; and eliminate payment for Hospital Acquired Conditions as defined by Medicare.

We conducted our review of your submittal according to the statutory requirements at sections, 1902(a), 1902(a)(13), 1902(a)(30), 1903(a) and 1923 of the Social Security Act and the regulations at 42 CFR 447 Subpart C. Before we can continue processing this amendment, we need additional or clarifying information.

The regulation at 42 CFR 447.252(b) requires that the State plan include a comprehensive description of the methods and standards used to set payment rates. Section 6002 of the State Medicaid Manual explains further that the State plan must be comprehensive enough to determine the required level of FFP and to allow interested parties to understand the rate setting process and the items and services that are paid through these rates. Further, since the plan is the basis for Federal financial participation, it is important that the plan's language be clear and unambiguous. Therefore, we have the following additional questions/concerns regarding TN 11-014.

1. Page 26a-Adjustment to Payment for Hospital Acquired Conditions (HACs).

   This section proposes to eliminate reimbursement for hospital acquired conditions based on the current Medicare identified conditions. However, these requirements are not in compliance with the Medicaid Program Provider-Preventable Conditions including Health Care-Acquired Conditions Regulations effective July 1, 2011. Please revise this section to be in compliance with these regulations.

Given the effect of provider rate reductions that have been implemented during this past year, CMS has concerns that access to care could be negatively impacted. While the State has provided CMS with information regarding actions that were taken to monitor access to care for Medicaid beneficiaries, we need additional information regarding the State's compliance with Section 1902(a)(30)(A) of the Social Security Act.

2. In your response to our access questions you indicated that you initiated strategies to capture baseline measures of access to care and you have an ongoing process to monitor access at the provider and recipient level. Please provide sample copies of these baseline measures and any reports developed to monitor access particularly any reports that identify by provider type the number of visits or days of care provided and a description of how you utilize the information.
3. In response to our question regarding studies or surveys you have implemented you indicated you have implemented a series of provider and recipient surveys and quality measures. Please provide copies of the surveys and any summary reports you have developed from these surveys. Also, please provide copies of any quality measures and how you use these measures and surveys to monitor access.
4. Based on the South Carolina's efforts to engage providers on the proposed rate reductions, did the State modify any proposed reductions as a result of provider input?
5. How often does the South Carolina Department of Health and Human Services review the reports/measures it uses to monitor access?

We are requesting this additional/clarifying information under provisions of section 1915(f) of the Social Security Act (added by PL 97-35). This has the effect of stopping the 90-day clock for CMS to take action on the material. A new 90-day clock will not begin until we receive your response to this request.

In accordance with our guidelines to all State Medicaid directors dated January 2, 2001, if we have not received the State's response to our request for additional information within 90 days from the date of this letter, we will initiate disapproval action on the amendment. In addition, because this amendment was submitted after January 2, 2001 and is effective after January 1, 2001, please be advised that we will continue to defer Federal financial participation (FFP) for State payments made in accordance with this amendment until it is approved. Upon approval, FFP will be available for the period beginning with the effective date through the date of approval.

Please submit your response to:

National Institutional Reimbursement Team
Attention: Mark Cooley
CMS, CMSO
7500 Security Boulevard, M/S S3-14-28
Baltimore, MD 21244-1850

If you have any questions or would like to discuss our comments and questions, please contact Stanley Fields at 502-223-5332.

Sincerely,

Jackie Glaze

Jackie Glaze
Associate Regional Administrator
Division of Medicaid and Children's Health Operations

Cc:

Venesa Day, CMCS
Sheri Gaskins, CMCS
Mark Cooley, CMCS
Stanley Fields, NIRT
Tim Weidler, NIRT
Davida Kimble, ROIV
Cheryl Wigfall, ROIV
Michelle White, ROIV
Mary Holly, ROIV

Log #000169 ✓

South Carolina Department of Health & Human Services

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

November 16, 2011

National Institutional Reimbursement Team
Attention: Mr. Mark Cooley
CMS, CMSO
7500 Security Boulevard M/S S3-14-28
Baltimore, Maryland 21244-1850

RE: Request for Additional Information (RAI) for South Carolina SC 11-014

Dear Mr. Cooley:

This is in response to Ms. Jackie Glaze's RAI letter dated October 5, 2011. Please note that while the South Carolina Department of Health and Human Services will address each question raised in the letter, it first wishes to make the following request.

The Department requests that it be allowed to separate the subject state plan amendment into an "A" and "B" version. Under SC 11-014(A), the Department will resubmit the original plan pages which would allow it to implement the July 11, 2011 payment reductions outlined in the plan as well as allow the Department to no longer reimburse hospitals for treatment related to Hospital Acquired Conditions as defined by Medicare for discharges effective on or after July 11, 2011. Next under SC 11-014(B), the Department will submit appropriate plan language to implement the provisions of the Medicaid Program Provider-Preventable Conditions including Health Care-Acquired Conditions Regulations effective July 1, 2011, which would have an actual compliance effective date of July 1, 2012. The approval of the above request from CMS and the subsequent submission of SC 11-014(B) by the Department will address CMS question #1.

Assuming that the response to our request has been approved by CMS, please find enclosed SC 11-014(A). The changes as described in our July 12, 2011 plan submission letter of SC 11-014 remain the same under this plan submission. Our responses to CMS questions #2 through #5 are as follows:

Reimbursement (Access of Care)

2. In your response to our access questions you indicated that you initiated strategies to capture baseline measures of access to care and you have an ongoing process to monitor access at the provider and recipient level. Please provide sample copies of these baseline measures and any reports developed to monitor access particularly any reports that identify by provider type the

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(803) 898-2504 • Fax (803) 255-8235

number of visits or days of care provided and a description of how you utilize the information.

Response: **Since 2007, the SCDHHS has been measuring access to care using a variety of differing methods to capture resource utilization, quality benchmarks, stakeholder concerns, and beneficiary satisfaction with care. These reports are currently posted on the Department's website at http://www.dhhs.state.sc.us/QualityReports.asp and http://www.scdhhs.gov/reports.asp . Building on these reports, the Department developed with the University of South Carolina a reporting framework to evaluate access to care. A copy of the methodology is attached for your review – *Assessment of Access to Care- SC Medicaid Program.* The assessment will be conducted at specific intervals –CY and FY– with the baseline established in CY 2010. The Department uses these reports to target quality improvement initiatives, identify and leverage provider resources and to assess financial patterns based on differing outcomes and provider arrangements.**

We have also enclosed an Excel Spreadsheet with analysis of providers participating in the Medicaid program.

3. In response to our question regarding studies or surveys conducted you indicated implementation of a series of provider and recipient surveys and quality measures. Please provide copies of the surveys and any summary reports you have developed from these surveys. Also, please provide copies of any quality measures and how you use these measures and surveys to monitor access to care.

Response: **The University of South Carolina under contract with the SCDHHS annually conducts and reports on the Consumer Assessment of Health Providers and Systems (CAHPS). The term refers to a comprehensive and evolving family of surveys that ask consumers and patients to evaluate the interpersonal aspects of health care. CAHPS surveys examine those aspects of care for which consumers and patients are the best and/or only source of information, as well as those that consumers and patients have identified as being important. A stratified random sample reflecting children, adults, special needs populations, CHIP, and CHIPRA beneficiaries residing in rural and urban settings is fielded annually. The completion rate is 32% for adults and 40% for children generalizable to the entire**

Medicaid population. In CY 2010, approximately 5,000 completed CAHPS surveys provided recipient input on the delivery and satisfaction with health care services. The state performance by health plan arrangement combined with CAHPS provides a platform for dialogue with individual health plans, the Medical Care Advisory Committee (MCAC), the Long Term Care and Nursing Homes Committee, and the Coordinated Care Council on targeted efforts for improvement and the identification of gaps in access to care.

It should be noted, measuring and reporting on quality performance and access to care plays a crucial role across all activities of the Department. This documentation seeks to ensure that provider cuts do not adversely affect access to care and the mechanisms exist to use this information to inform program and policy decisions. Lastly, these reports are a requirement under legislative provisos adding an additional reporting and oversight requirement to ensure provider cuts are data-driven. These reports are currently posted on the Department's website at http://www.dhhs.state.sc.us/QualityReports.asp and http://www.scdhhs.gov/reports.asp.

A copy of the CAHPS Surveys is enclosed for your review.

4. Based on the South Carolina's efforts to engage providers on the proposed rate reductions, did the State modify any proposed reductions as a result of provider input?

Response: Yes.

5. How often (i.e. frequency) does the South Carolina Department of Health and Human Services review the reports/measures it uses to monitor access?

Response: At a minimum the Department formally reports on access to care quality measures twice a year. However, the data are compiled on a quarterly basis allowing for the identification of changes in access to care requiring intervention. The CAHPS are conducted and reported annually.

We look forward to the approval of our request as well as to the approval of SC 11-014(A). If you or your staff should have any questions, please contact Jeff Saxon at (803) 898-1023.

Sincerely,

Anthony E. Keck
Director

AEK/hsh

Enclosures

cc: Ms. Jackie L. Glaze
Associate Regional Administrator, CMS