DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Myers/Waldrep	2-11-10

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 101334	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR cc: Ms. Forkners, Dept, CMS file Cleared 3/2/10, letter attached.	[X] Prepare reply for appropriate signature DATE DUE 2-25-10
	[ ] 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. Gave Faye H. Original Copy on 3/12/10			
2.			
3.			
4.			

From: Richard Kluender
To: Brenda James
CC: Felicity Myers; Jan Polatty
Date: 2/11/2010 12:34 PM
Subject: Fwd: SC 09-011 Official Request for Additional Information
Attachments: SC09-011 Signed RAI.pdf

Could we please get the attached letter logged to our Bureau.

Thanks

Rich
>>> "Hodges, Tandra L. (CMS/SC)" <Tandra.Hodges@cms.hhs.gov> 2/11/2010 7:55 AM >>>

Good morning,
Please see the attached Request for Additional Information regarding SC 09-011. If you see that someone has not been included on this email, please forward the information to them. The hardcopy has been mailed to the State.

"Excellence is not an exception; it is a prevailing attitude". . . Colin Powell

Tandra Hodges
Centers for Medicare & Medicaid Services
Division of Medicaid & Children's Health
61 Forsyth Street, SW, Suite 4T20
Atlanta, Georgia 30303
Phone: (404) 562-7409
Fax: (404) 562-7481
Tandra.Hodges@cms.hhs.gov

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

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

February 10, 2010

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

Dear Ms. Forkner:

We have reviewed the proposed State Plan Amendment (SPA) SC 09-011 Rehabilitation Services related to behavior health. The 90th day is February 28, 2010. In order for the Centers for Medicare & Medicaid Services (CMS) to better understand the services proposed by the State in SC 09-011, we are submitting this Request for Additional Information (RAI). We are available to discuss any question the State may have about the RAI.

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

Coverage Questions

1. Attachment 3.1-A, Limitation Supplement, Page 6b – As presently worded, the first sentence of the first paragraph may be interpreted to mean that the federal regulation that governs rehabilitative services includes only behavioral health services. Please revise the first sentence to delete reference to the regulation that governs rehabilitative services: "Behavioral health services are available to all Medicaid beneficiaries who meet the medical necessity criteria for these services." Thereafter, please refer to these services in the SPA generically as "Rehabilitative behavioral health services" or just "Behavioral health services".

(For example, the third sentence in the first paragraph; the last sentence in the second paragraph; the first sentence under Diagnostic Assessment; the second sentence of the first paragraph under Staff Qualifications and the sentence before the table of the qualifications.)

2. Please confirm that the State has intentionally omitted "Intensive Family Services" from the proposed services in SC 09-011 and does not intend to furnish this bundled service.

3. Individual and Group Therapy – Has the State inadvertently omitted the statement about who the providers are, the billing and the units of service or does the State intend the provision at the end of "Family Therapy" to apply to all three of the therapies. If the former, please include the information. If the latter, please modify the first sentence of the third paragraph under "Family Therapy" as follows: "Individual, Group and Family Therapy services are…"

4. Behavior Modification – Please confirm that all children who are determined to need this service may receive this service.

5. Peer Support Services – We do not get a clear picture of what peer support services are and what the peer support specialist will do. Please be more concrete in the description of the services provided by, and the role and responsibilities of, the peer support specialist. Please also add to the qualifications section that the peer support specialist works under the supervision of a qualified clinical professional, and list who those professionals are.

6. Please add the educational requirements to the provider qualifications table for the Licensed Practical Nurse.

7. In the staff qualifications chart starting on Page 6c.5 of Attachment 3.1-A, in the Supervision column, several of the Professional Types have very specific information. (Examples of this include Physician Assistant, APRN, RN, and LPN. However, many of the Professional Types (LMSW, Certified Substance Abuse Professional, LBSW, Clinical Chaplain, MHP, SAP, Behavior Analyst, Clinical Service Professional, Early Interventionist, Mental Health Specialist, Substance Abuse Specialist and PSS) have the same generic supervision requirement that is unclear to us. Please be more specific for each professional type what type or level of supervision is required.

Financial Management Questions

1. When reviewing the new plan, we noticed the public notice was not included. Please provide a copy of the public notice and public announcement in a state register similar to the Federal Register or the newspaper of the widest circulation in the State.

2. In prior conversations with SC, the State mentioned discussions were in process in regards to cost settling governmental rehab service providers. Please submit any SPA language (cost identification process) or supplemental detail for us to evaluate.

CMS 179

3. There is a significant difference in the Federal Budget Impact between FFY's 2010 and 2011. What are the underlying factors driving this major increase between years?

Page 4.19B, Page 6.1

4. Please provide a reimbursement demonstration of what is being described in paragraphs 1-4.

Page 4.19B, Page 6.1b

5. The formatting on this page appears to be incorrect. Please resubmit this page in the appropriate formatting whereas the *Attachment 4.19B; Page 6.1b* appears in the upper right hand corner and the double font that can be seen down the center of the page is removed.

6. Per paragraph 1, the provider types listed do not match the provider types listed in the provider type table. Please explain the discrepancy and make the appropriate corrections where necessary. The reimbursement page should mirror the coverage page.

7. Does the State currently have a reconciliation process in place to support steps 1-8? If, so, please provide a detail demonstration?

8. Step 1 appears to be missing from the page, please add it.

Page 4.19B, Page 6.1c

9. Per step #7, the 'level of effort' of providing specific rehab services by provider type, a work adjustment factor will be applied to the hourly billing rate previously adjusted for provider supervision as determined in step #6 / The 'level of effort adjustment was developed by dividing the work units for each of the procedure codes by the overall average work units for the universe of target procedure codes. For clarification purposes, please provide the computation to support this and explain why this computation is deemed necessary.

Page 4.19B, Page 6.1d

10. Is this methodology still applicable to this service? If not, please remove.

ARRA Questions

Please indicate whether, 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 (MOE);
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).

Standard Funding Questions:

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

2. Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state share of each type of Medicaid payment (normal per diem, supplemental, enhanced, other) is funded. Please describe whether the state share is from appropriations from the legislature to the Medicaid agency, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either through an IGT or CPE. In this case, please identify the agency to which the funds are appropriated. Please provide an estimate of total expenditure and State share amounts for each type of Medicaid payment. If any of the non-federal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the state agency receives the transferred amounts from the local governmental entity transferring the funds.

If CPEs are used, please describe the methodology used by the state to verify that the total expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b). For any payment funded by CPEs or IGTs, please provide the following:

(i) a complete list of the names of entities transferring or certifying funds;
(ii) the operational nature of the entity (state, county, city, other);
(iii) the total amounts transferred or certified by each entity;
(iv) clarify whether the certifying or transferring entity has general taxing authority: and,
(v) whether the certifying or transferring entity received appropriations (identify level of appropriations).

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

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

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

If you have any questions related on this request for additional information please contact Michelle White at (404) 562-7328 on fiscal issues or Tandra Hodges at (404) 562-7409 on programmatic issues. Upon CMS approval, FFP will be available for the period beginning with the effective date through the date of actual approval.

Sincerely,

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

Log 334

State of South Carolina
Department of Health and Human Services

Mark Sanford
Governor

Emma Forkner
Director

March 2, 2010

Ms. Jackie L. Glaze
Acting Associate Regional Administrator
Center for Medicare and Medicaid Services
Division of Medicaid & Children's Health
Atlanta Regional Office
61 Forsyth Street, SW- Suite 4T20
Atlanta, Georgia 30303-8909

RE: Response to the South Carolina Title XIX State Plan Amendment SC 09-011 Request for Additional Information Letter Dated February 10, 2010

Dear Ms. Glaze:

The South Carolina Department of Health and Human Services (SCDHHS) is providing the following responses to the questions raised in the Centers for Medicare and Medicaid Services Request for Additional Information letter dated February 10, 2010. This information is submitted to ensure the State meets all statutory and regulatory requirements for Medicaid rehabilitation services related to behavioral health.

Coverage Questions

1. Attachment 3.1-A, Limitation Supplement, Page 6b – As presently worded, the first sentence of the first paragraph may be interpreted to mean that the federal regulation that governs rehabilitative services includes only behavioral health services. Please revise the first sentence to delete reference to the regulation that governs rehabilitative services: "Behavioral health services are available to all Medicaid beneficiaries who meet the medical necessity criteria for these services." Thereafter, please refer to these services in the SPA generically as "Rehabilitative behavioral health services" or just "Behavioral health services". (For example, the third sentence in the first paragraph; the last sentence in the second paragraph; the first sentence under Diagnostic Assessment; the second sentence of the first paragraph under Staff Qualifications and the sentence before the table of the qualifications.)

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

Response: Attachment 3.1-A, Limitation Supplement, Page 6b – The state agrees that as presently worded, the first sentence of the first paragraph may be interpreted to mean that the federal regulation that governs rehabilitative services only includes behavioral health services. The state will revise the first sentence to delete reference to the regulation that governs rehabilitative services as follows: "Behavioral health services are available to all Medicaid beneficiaries who meet the medical necessity criteria for these services." Thereafter, the state will refer to the services in the SPA generically as "rehabilitative behavioral health services" or just "behavioral health services". (For example, the State will revise the language in the third sentence in the first paragraph; the last sentence in second paragraph; the first sentence under Diagnostic Assessment; the second sentence of the first paragraph under Staff Qualifications and the sentence before the table of the qualifications.)

2. Please confirm that the State has intentionally omitted "Intensive Family Services" from the proposed services in SC 09-011 and does not intend to furnish this bundled service.

   Response: Yes, the State has intentionally omitted "Intensive Family Services" from the proposed services in SC 09-110 and does not intend to furnish this bundled service. The State will continue to cover a similar service under the demonstration Home and Community-Based 1915c Waiver approved by CMS for SED children that meet Level of Care for Inpatient Psychiatric Services for Children Under 21.

3. Individual and Group Therapy – Has the State inadvertently omitted the statement about who the providers are, the billing and the units of service or does the State intend the provision at the end of "Family Therapy" to apply to all three of the therapies. If the former, please include the information. If the latter, please modify the first sentence of the third paragraph under "Family Therapy" as follows: "Individual, Group and Family Therapy services are "

   Response: The State does intend the provision at the end of "Family Therapy" to apply to all three of the therapies. The State will modify the first sentence of the third paragraph under "Family Therapy" as follows: "Individual, Group and Family Therapy services are...."

4. Behavior Modification – Please confirm that all children who are determined to need this service may receive this service.

   Response: The State confirms that all children who are determined to need Behavior Modification may receive this service.

5. Peer Support Services – We do not get a clear picture of what peer support services are and what the peer support specialist will do. Please be more concrete in the

description of the services provided by, and the role and responsibilities of, the peer support specialist. Please also add to the qualifications section that the peer support specialist works under the supervision of a qualified clinical professional, and list who those professionals are.

Response: The Peer Support Services description has been replaced with the following language to provide a clearer picture of what this service is intended to do and the services, role and responsibilities of the Peer Support Specialist. The Peer Support Specialist must be supervised by a master's level clinical professional. This information has been added to the qualifications section of the document:

Peer Support Service: This service is provided to adults. The purpose of this service is to allow people with similar life experiences to share their understanding to assist beneficiaries in their recovery from mental illness and/or substance use disorders. The Peer Support Specialist gives advice and guidance, provides insight, shares information on services and empowers the beneficiary to make healthy decisions. The unique relationship between the Peer Support Specialist and the beneficiary fosters understanding and trust in beneficiaries who otherwise would be alienated from treatment. The beneficiary's plan of care determines the focus of this service.

This service is person centered with a recovery focus and allows beneficiaries the opportunity to direct their own recovery and advocacy process. The service promotes skills for coping with and managing symptoms while utilizing natural resources and the preservation and enhancement of community living skills.

The Peer Support Specialist will utilize their own experience and training to assist the beneficiary in understanding how to manage their illness in their daily lives by helping them to identify key resources, listening and encouraging beneficiaries to cope with barriers and work towards their goals. The Peer Support Specialist will also provide ongoing support to keep beneficiaries engaged in proactive and continual follow up treatment.

The Peer Support Specialist actively engages the beneficiary to lead and direct the design of the plan of care and empowers the beneficiary to achieve their specific individualized goals. Beneficiaries are empowered to make changes to enhance their lives and make decisions about the activities and services they receive. The Peer Support Specialist guides the beneficiary through self-help and self-improvement activities that cultivate the client's ability to make informed independent choices and facilitates specific, realistic activities that lead to increased self-worth and improved self-concepts.

6. Please add the educational requirements to the provider qualifications table for the Licensed Practical Nurse.

Response: The educational requirement for a Licensed Practical Nurse is a high school diploma or equivalent and completion of an accredited nursing program approved by the Board of Nursing. This information has been added to the provider qualifications table.

7. In the staff qualifications chart starting on Page 6c.5 of Attachment 3.1-A, in the Supervision column, several of the Professional Types have very specific information. (Examples of this include Physician Assistant, APRN, RN, and LPN. However, many of the Professional Types (LMSW, Certified Substance Abuse Professional, LBSW, Clinical Chaplain, MHP, SAP, Behavior Analyst, Clinical Service Professional, Early Interventionist, Mental Health Specialist, Substance Abuse Specialist and PSS) have the same generic supervision requirement that is unclear to us. Please be more specific for each professional type what type or level of supervision is required.

   Response: The State has revised the staff qualifications chart starting on Page 6c.5 of Attachment 3.1-A, in the supervision column to reflect very specific information for each professional type and level of supervision required.

Financial Management Questions

1. When reviewing the new plan, we noticed the public notice was not included. Please provide a copy of the public notice and public announcement in a state register similar to the Federal Register or the newspaper of the widest circulation in the State.

   Response: The South Carolina Department of Health and Human Services (SCDHHS) will provide a copy of the public notice when it is published, no later than March 15, 2010 in The State, Post and Courier, and Greenville News.

2. In prior conversations with SC, the State mentioned discussions were in process in regards to cost settling governmental rehab service providers. Please submit any SPA language (cost identification process) or supplemental detail for us to evaluate.

   Response: The SCDHHS has updated and enclosed pages 6.1d and 6.1e of Attachment 4.19-B to address the cost settlement language.

CMS 179

3. There is a significant difference in the Federal Budget Impact between FFY's 2010 and 2011. What are the underlying factors driving this major increase between years?

   Response: The difference in the two amounts is due to the effective date of the state plan. Since the state plan will be effective July 1, 2010, only three months of the

annual projected annual cost increase in federal financial participation would be reflected in FFY 2010 while 100% of the annual projected cost increase would be reflected in FFY 2011.

Page 4.19B, Page 6.1

4. Please provide a reimbursement demonstration of what is being described in paragraphs 1-4.

   Response: The SCDHHS is enclosing an example for your review which describes the salary computation for Licensed Masters Social Worker (LMSW) – please see attachment A.

Page 4.19B, Page 6.1b

5. The formatting on this page appears to be incorrect. Please resubmit this page in the appropriate formatting whereas the *Attachment 4.19B; Page 6.1b* appears in the upper right hand corner and the double font that can be seen down the center of the page is removed.

   Response: The SCDHHS has revised the page as requested and it is enclosed.

6. Per paragraph 1, the provider types listed do not match the provider types listed in the provider type table. Please explain the discrepancy and make the appropriate corrections where necessary. The reimbursement page should mirror the coverage page.

   Response: The state has corrected for this error and has also included two new provider types (i.e. pharmacist and applied behavior analyst – bachelor's level) in the revised page that is enclosed.

7. Does the State currently have a reconciliation process in place to support steps 1-8? If, so, please provide a detail demonstration?

   Response: The SCDHHS is providing a copy of our rate calculation worksheet for your review and it is enclosed (see attachment B).

8. Step 1 appears to be missing from the page, please add it.

   Response: Step #1 of the eight step process begins on page # 6.1 which is enclosed.

Page 4.19B, Page 6.1c

9. Per step #7, the 'level of effort' of providing specific rehab services by provider type, a work adjustment factor will be applied to the hourly billing rate previously adjusted for provider supervision as determined in step #6 / The 'level of effort adjustment was developed by dividing the work units for each of the procedure codes by the overall average work units for the universe of target procedure codes. For clarification purposes, please provide the computation to support this and explain why this computation is deemed necessary.

   Response: The SCDHHS has enclosed attachment C which provides the computation of the relative values. The purpose of this adjustment is to account for the level of effort required from each of the provider types to perform the various rehabilitative behavioral health services listed within the plan amendment.

Page 4.19B, Page 6.1d

10. Is this methodology still applicable to this service? If not, please remove.

    Response: Rehabilitative services for primary care enhancement is a separate service that is not covered under the rehabilitative behavioral health services state plan amendment and thus should remain. Therefore, the SCDHHS respectfully requests that in the event CMS has concerns with this service that it be addressed in a separate plan amendment and not hold up approval of the subject plan amendment.

ARRA Questions

Please indicate whether, 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 (MOE);
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).

Response: The state is in compliance with the terms of the American Recovery and Reinvestment Act (ARRA).

Standard Funding Questions:

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 09-011, providers of services under this plan retain 100% of the fee schedule payments that will be reimbursed under this state plan amendment effective July 1, 2010.

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).

SCDHHS Response:

Behavioral Health Rehab Services	Certified Public Expenditures (CPE) and Intergovernmental Transfers (IGTs) from the SC Continuum of Care (SCCOC), SC Department of Mental Health (SCDMH), Medical University Hospital Authority (MUSC), SC Department of Alcohol and Other Drug Abuse Services (SCDAODAS), SC Department of Disabilities and Special Needs (SCDDSN), SC Dept. of Education (SCDOE), SC Department of Juvenile Justice (SCDJJ), SC School for Deaf and Blind (SCSD&B), and SC Department of Social Services (SCDSS) Which are State Appropriations

The SCCOC, SCDMH, SCDAODAS, SCDDSN, SCDOE, SCDJJ, and SCDSS, via IGTs, transfer state appropriations for services provided by both private and non-state government owned providers of behavioral health rehab services for their Medicaid eligible population. The SC state agencies are required to transfer the state matching funds in advance, prior to the Medicaid enrolled providers of behavioral health rehab services submitting their claims for Medicaid reimbursement. The SCSD&B also transfers IGTs for the services that the agency provides, and the SCDOE transfers state funds via IGT for the services provided by the LEAs (Local Educations Agencies).

The SCCOC, SCDMH, SCDDSN, SCDJJ, SCDSS, and MUSC use certified public expenditures (CPE) as the source of state matching funds. The state agencies file annual cost reports to the SCDHHS which are used for rate setting, cost settlement, and as documentation of CPE. The Internal Audit Division within SCDHHS is planning to conduct audits of state agency Medicaid services during SFY 2010. Additionally, CPE contract language has been developed and is incorporated into each of the agency's contract:

"The (state agency) agrees to incur expenditures from state appropriated funds and/or funds derived from tax revenue in an amount at least equal to the non-federal share of the allowable, reasonable and necessary cost for the provision of services to be provided to Medicaid recipients under this contract prior to submitting claims for payment under this contract. Documentation of the non-federal expenditures necessary to support the claims for reimbursement must be maintained by the state agency and are subject to audit by SCDHHS. SCDHHS may withhold and/or recoup reimbursements if Certified Public Expenditures are not adequately documented. As required by 45 CFR Part 201.5, all funds expended for the non-federal share of this

contract must be in compliance with 42 CFR Part 433 Subpart B. Such non-federal funds must be actually expended for the provision of services to be provided under this contract."

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 09-011 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:
   There will be supplemental payments made to state-owned governmental providers of behavioral health rehab services under this specific plan amendment. These payments are retrospective cost settlements and on an annual basis are estimated to amount to approximately $10,000,000 total dollars.

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.

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 non-state owned governmental providers of behavioral health rehab services under SC 09-011 would not exceed the reasonable costs of providing the services. State owned governmental providers of these services will be subject to retrospective cost settlements. Therefore, in the event that payments are in excess of their reasonable allowable Medicaid costs, the SCDHHS will recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report.

We appreciate the extensive technical assistance offered by CMS throughout this process. If you have any questions or requests concerning these matters, please contact either Felicity Myers at 803-898-2803 or Jeff Saxon at 803 898-1023.

Sincerely,

Emma Forkner
Director

EF/wswh

Enclosures