DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Myers	3-1-10

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 100368	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR cc: Ms. Fortner, Deps, CMS file, Hard Copy came in 3/1/10	[ ] Prepare reply for appropriate signature DATE DUE _____ [ ] FOIA DATE DUE _____ [X] 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.			

From:	"Gavens, Jay C. (CMS/CMCHO)" <Jay.Gavens@cms.hhs.gov>
To:	<forkner@scdhhs.gov>
CC:	<Wells@scdhhs.gov>, "Wilkerson, Joyce C. (CMS/SC)" <Joyce.Wilkerson@cms....
Date:	2/26/2010 11:26 AM
Subject:	FMR Final Report 04-FS-2008-SC-01-F
Attachments:	FMR 04-FS-2008-SC-01-F 022410.pdf

Please find attached a soft copy of our Final Report relating to our Financial Management Review (FMR) of South Carolina's Rehabilitative Services. The hard copy is in the mail. Please let us know if you have any questions - we appreciate the assistance and courtesy of your staff during this review.

Jay Gavens, Chief

Financial Management and Information Systems Branch

Division of Medicaid and Children's Health Operations

CMS-Atlanta

404 562 7430

Department of Health & Human Services
Centers for Medicare & Medicaid Services
Division of Medicaid & Children's Health Operations
61 Forsyth St., Suite 4T20
Atlanta, Georgia 30303-8909

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Control Number: 04-FS-2008-SC-01-F

February 24, 2010

Emma Forkner, Director
South Carolina Department of
Health and Human Services
P. O. Box 8206
Columbia, SC 29202-8206

Re: Final Report - Financial Management Review of South Carolina Mental Health Rehabilitative Services

Dear Ms. Forkner:

Please find enclosed the final report of our Financial Management Review of South Carolina's Mental Health Rehabilitative Services for the period of July 1, 2006 through June 30, 2007. We have reviewed and incorporated the comments suggested by your staff into our final report. Also, upon review and consideration of the additional information provided for finding "C", we have removed all language pertaining to room and board as part of the all inclusive rate in our final report.

We appreciate the courtesy and cooperation extended by your staff as well as the various providers visited during this process. If you have any questions or need additional information, please contact Joyce Wilkerson at 404-562-7426 or Cheryl Wigfall at 803-252-7172.

Sincerely,

Jackie Glaze

Jackie Glaze
Acting Associate Regional Administrator

Enclosure

Financial Management Review

SOUTH CAROLINA

MENTAL HEALTH REHABILITATIVE SERVICES

STATE FISCAL YEAR 2007

FINAL REPORT

CONTROL NUMBER: 04-FS-2008-SC-01-F

REPORT DATE: FEBRUARY 24, 2010

CMS

CENTERS for MEDICARE & MEDICAID SERVICES

Prepared by:
Financial Management Branch 1
Division of Medicaid and Children's Health Operations
Atlanta Regional Office

I. INTRODUCTION/BACKGROUND

Introduction

The Atlanta Regional Office (RO) of the Centers for Medicare and Medicaid Services (CMS), Division of Medicaid and Children's Health Operations, Financial Management Branch completed a Financial Management Review (FMR) of South Carolina's Mental Health Outpatient Rehabilitative Services (MHORS) that were provided by other state agencies/other providers and reimbursed by the South Carolina Department of Health and Human Services (SCDHHS) using Federal Financial Participation (FFP). SCDHHS is the single state agency responsible for administering the Medicaid program in the State of South Carolina.

Background

Title XIX of the Social Security Act (the Act) authorizes Federal grants for Medicaid programs that provide medical assistance to low income families, elderly, and persons with disabilities. Section 1902(a)(30) of the Act requires a State Plan to meet certain requirements in setting payment amounts for covered Medicaid services. One of these requirements is that payment for care and services under an approved plan are consistent with efficiency, economy, and quality of care. Although states have considerable flexibility in designing their individual State Plan, each state must comply with Federal laws and regulations in the operation of the Medicaid program in accordance with an approved State Plan. Otherwise, the state could put their FFP at risk for those services. Further, the Act requires rates for services in the State Plan to be economical and efficient; thereby prohibiting bundling of services or rates. Additionally, 42 Code of Federal Regulation (CFR) 447.201 requires the State Plan to describe the policy and the methods to be used in setting payment rates for each type of service included in the State's Medicaid program.

Under 42 CFR 430.10 authority, the State Plan should describe the nature and scope of its Medicaid program and give assurance it will be administered in conformity with the specific requirements of Title XIX and noncompliance in practice would put the state's FFP at risk.

Section 1905(i) of the Act, defines an Institution for Mental Diseases (IMD) as a hospital, a nursing facility, or an institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases. Further, Section 1905(a) of the Act, states that FFP is not available for services to residents under the age of 65 who are in an IMD.

42 CFR (440.160; Part 441, Subpart D; and Part 483, Subpart G) provide Medicaid rules that only psychiatric residential treatment facilities (PRTF) would be able to meet the conditions for participation in Medicaid for individuals under the age of 21 receiving inpatient psychiatric services.

Under SCDHHS' current approved State Plan Amendment (SPA) 07-001, Attachment 3.1-A, Limitation Supplement, page 6b, Section 13d under the heading Rehabilitative Services, the plan language specifically states, *"... the following services are considered rehabilitative services: Outpatient mental health rehabilitative services meeting standards as determined by the South Carolina Department of Health and Human Services."* On June 30, 2008, SCDHHS submitted to CMS State Plan Amendment (SPA) 08-014 to replace SPA 07-001 in order to revise current SPA language to comply with 42 CFR 447.201. Currently, this SPA is off- the-clock.

II. PURPOSE AND SCOPE

The purpose of our review was to determine whether South Carolina (MHORS) claimed during state fiscal year 2007 were reimbursed in accordance with Federal statutes, regulations and guidelines. Specifically, to determine whether:

- MHORS were eligible for Federal Financial Participation (FFP);
- MHORS were valid covered services in the State Plan;
- Claims were supported by proper documentation of service;
- Providers maintained proper case records;
- Paid claims included services that were intrinsic to programs other than Medicaid such as vocational training, foster care, education, housing, etc.

To accomplish our objective we:

- Reviewed Federal statues, regulations, and guidelines for MHORS;
- Reviewed relevant SPAs;
- Conducted interviews with State officials to gain an understanding of the State's oversight of the MHORS;
- Reviewed fee schedules for MHORS;
- Obtained, reviewed, and compared selected MHORS service procedure codes and service descriptions to the state plan;
- Obtained and reviewed provider manuals for selected MHORS;
- Identified expenditures claimed on the CMS-64;
- Conducted six provider site visits and reviewed a select sample of claims.

Our field work was performed at SCDHHS in Columbia, SC and at various provider locations in South Carolina and bordering states from December 2007 to July 2008.

III. FINDINGS and RECOMMENDATIONS

A. Services Ineligible for Federal Financial Participation (FFP)

During our review of six facilities (providers) in conjunction with reviewing the South Carolina Medicaid State Plan for rehabilitative services, South Carolina Provider Manual, case files, and paid claims documentation, we noted several services (see table on page 3) that were paid to the providers by SCDHHS for which SCDHHS claimed FFP on the CMS 64. However, those rehabilitative services were not in the State Plan and therefore not eligible to receive FFP.

During the period of July 1, 2006 thru June 30, 2007, SCDHHS received FFP in the amount of $33,419,031 for those services (*see Table I on page 3*). Thus, SCDHHS is in violation of 42 CFR 430.10 which states:

> "The State plan is 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".

Table I:

Rehabilitative Service Description	**Code**	**Unit of Service**	**FFP 07/01/2006 - 06/30/2007**[1]
Mental Health Services Not Otherwise Specified (formerly Intensive Family Services (IFS))	H0046	15 minutes	$2,845,836
Therapeutic Foster Care (TFC)	S5145	Daily	$15,320,727
Therapeutic Behavioral Services (formerly Supervised Independent Living)	H2020	Daily	$719,419
Therapeutic Behavioral Services (formerly High/Moderate Management)	H2020	Daily	$12,739,142
Psychosocial Rehabilitation Services (formerly Clinical Day Program)	S8145	Daily	$1,501,949
Sexual Offender Treatment (formerly Specialized Treatment for Sex offenders)	H2029	Daily	$291,958
Total			**$33,419,031**

Additionally, we noted that SCDHHS did not distinctly define, describe, or identify the discrete rehabilitative services as required by 42 CFR 440.130 (d) in conjunction with 42 CFR 430.10 in their Medicaid State plan on Attachment 3.1-A pages 6.b-6c. Further, it was determined that SCDHHS' Medicaid State Plan on Attachment 4.19-B pages 6.1-6.2 for rehabilitative services does not adequately describe the payment methodology for each type of service. As such, the State did not comply with 42 CFR 447.201 which states:

> "The plan must describe the policy and the methods to be used in setting payment rates for each type of service included in the State's Medicaid program".

Under SCDHHS' current approved State Plan Amendment (SPA) 07-001, Attachment 3.1-A, Limitation Supplement, page 6b, Section 13d under the heading Rehabilitative Services, the plan language specifically states, *"... the following services are considered rehabilitative services: Outpatient mental health rehabilitative services meeting standards as determined by the South Carolina Department of Health and Human Services."* On June 30, 2008, SCDHHS submitted to CMS State Plan Amendment (SPA) 08-014 to replace SPA 07-001 in order to revise current SPA language to comply with 42 CFR 447.201. Currently, this SPA is off- the-clock.

[1] The FFP amount includes all facilities/providers during the SFY 2007.

RECOMMENDATION

We recommend SCDHHS;

(1) Provide CMS with a corrective action plan for revising SPA 08-014 such that the SPA would contain appropriate language for 3.1-A and 4.19-B pages ensuring that the services are described in a clear, distinct, and identifiable language that complies with the Federal guidelines and requirements. The SPA should also include appropriate payment methodology for each type of service that conforms to Federal guidelines. The corrective action plan for the revision of SPA 08-014 should be time limited to ensure reasonable submission of an approvable SPA. However, CMS may defer future claims on the CMS-64 until this finding is resolved.

State Response

The State has continued to work with CMS RO and CO over the last two years to add the level of specificity for the discrete services desired by CMS.

Based on direction from CMS RO, the state submitted the 3.1-A section of this SPA on June 30, 2008 as SPA 08-014, with the understanding that a complete SPA would follow. During this time period both program and reimbursement staff have worked with CMS CO and RO to ensure that the service descriptions, provider qualifications, and reimbursement methodology were in compliance with federal guidelines. There has been extensive interaction with public and private providers regarding the "provider contracting" option for reimbursement; these discussions were essential, but significantly slowed the development of the final services and rates. The State submitted its revised SPA to CMS for approval in November 2009.

CMS Comments

CMS accepts the State's response. On November 30, 2009, we received SPA 09-011, which replaces SPA 08-014. We will work with the State towards an approvable SPA that will resolve this particular issue.

B. Facilities Ineligible for Federal Financial Participation (FFP)

During our review of six facilities (providers) in conjunction with reviewing the South Carolina Medicaid State Plan for rehabilitative services, South Carolina Provider Manual, case files, and paid claims documentation, we noted two facilities that have more than 16 beds and are engaged in providing diagnosis, treatment, or care of persons with mental diseases. We consider those facilities to be institutions for mental diseases (IMD) and that SCDHHS should not have billed the Federal Medicaid program for services furnished to beneficiaries under the age of 65 , unless the beneficiaries were under the age of 21 and these facilities met the requirements of 42 CFR 440.160 and 42 CFR 441.151. All of the claims sampled were for beneficiaries under the age of 65.

During a further review of the SCDHHS provider listing, we discovered SCDHHS has a total of 26 facilities (see Table II below) that we consider IMDs. Additionally, we noted only one of the 26 facilities is authorized as a PRTF by the licensee agency, South Carolina Department of Health and Environmental Control (SCDHEC). SCDHHS improperly claimed FFP for services provided in 25 facilities that are deemed IMDs.

Table II:

Description of Facility	Total # of Facilities	Number of Facilities w/ 16 beds or less	Number of Facilities w/ 17 beds or more	Licensed PRTF[2]
Supervised Independent Living	7	6	1	0
Moderate Management Group Home	16	6	10	0
High Management Group Home	29	14	15	1
Total	**52**	**26**	**26**	**1**

SCDHHS did not comply with the following Federal laws, regulations, and guidelines that define IMD and prohibit FFP for services to residents under the age of 65 who are in an IMD:

- Social Security Act, section 1905(a) states "The term "medical assistance" means payment of part or all of the cost of the following care and services….."
- Social Security Act, section 1905 (a)(16) states "effective January 1, 1973, inpatient psychiatric hospital services for individuals under age 21, as defined in subsection (h)"
- Social Security Act, section 1905 (a) (28) (B) states "any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary except as otherwise provided in paragraph (16), such term does not include—(B) any such payments with respect to care or services for any individual who has not attained 65 years of age and who is a patient in an institution for mental diseases"
- Social Security Act, section 1905 (h)(1) states "For purposes of paragraph (16) of subsection (a), the term "inpatient psychiatric hospital services for individuals under age 21" includes only—(A) inpatient services which are provided in an institution (or distinct part thereof) which is a psychiatric hospital as defined in section 1861(f) or in another inpatient setting that the Secretary has specified in regulations"
- Social Security Act, section 1905 (h) and 42 CFR of the Code of Federal Regulations (440.160; Part 441, Subpart D; and Part 483, Subpart G) provide Medicaid rules that only psychiatric residential treatment facilities (PRTFs) would be able to meet the conditions for participation in Medicaid as institutional care
- Social Security Act, section 1905(i) states" The term "institution for mental diseases" means a hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services

[2] Only one facility with 17 beds or more is noted as being licensed by the South Carolina Department of Environmental Control (DHEC) as a residential treatment facility as of August 5, 2008.

RECOMMENDATION

We recommend SCDHHS

(1) Comply with Federal guidelines and cease claiming FFP for those facilities that are deemed IMDs on the CMS 64.
(2) Establish proper edits to their Medicaid Management Information System (MMIS) to ensure that these facilities are not reimbursed using FFP.
(3) Provide CMS with a corrective action plan to resolve these findings; failure to comply may place FFP at risk.

State Response

The State has completely resolved issues that resulted in this finding. The State no longer claims FFP for any non-institutional residential facilities that could be considered an IMD, to include those identified on Table II of this report. For Therapeutic Behavioral Health Services (High Management, Moderate Management, and Supervised Independent Living), we transitioned to 100% State funding for these facilities over an 18 month period, beginning August 1, 2007 and ending December 31, 2008. As indicated in the Medicaid Bulletin dated July 24, 2007, the State reduced the treatment rate for these facilities by 45% on August 1, 2007. As evidenced by our letter to providers, dated December 19, 2008, the State ceased payment for treatment in these facilities for dates of service on or after January 1, 2009. The State's MMIS system accurately reflects this policy and has multiple edits in place to ensure these facilities are not reimbursed for dates of service on or after January 1, 2009.

CMS Comments

CMS accepts the State's response. We will monitor this during our quarterly review process.

C. Bundled Rates/Services

During our review of six facilities in conjunction with reviewing the South Carolina Medicaid State Plan for rehabilitative services, South Carolina Provider Manual, case files, and paid claims documentation, we determined that the SCDHHS uses bundled payments to reimburse for the services listed below (Table III). Specifically, SCDHHS uses bundled rates that appear to reimburse at the same payment level regardless of the types of services provided, the types of practitioners who provide the service, or the number of services received by a beneficiary. CMS policy prohibits the use of bundled payment rates for non-institutional services because such rates violate the requirements of Section 1902(a)(30)(A) and 1902(a)(32) of the Act.

Table III:

Rehabilitative Service Description	Code	Unit of Service
(1) Mental Health Services Not Otherwise Specified (formerly Intensive Family Services (IFS))	H0046	15 minutes
(2) Therapeutic Foster Care (TFC)	S5145	Daily
(3) Therapeutic Behavioral Services (formerly Supervised Independent Living)	H2020	Daily
(4) Therapeutic Behavioral Services (formerly High/Moderate Management)	H2020	Daily
(5) Psychosocial Rehabilitation Services (formerly Clinical Day Program)	S8145	Daily
(5) Sexual Offender Treatment (formerly Specialized Treatment for Sex offenders)	H2029	Daily

These rates are not viewed by CMS as economic and efficient, as required by 1902(a)(30)(A) of the Act. For example, the TFC daily rates are based on an annual budgeted unit of service. The unit of service is determined by averaging the annual cost of treatment based on the qualification of the lead practitioner, and the number and supervision of the foster parent. Therapeutic Behavioral Services daily rate is determined by averaging the annual budgeted costs and services utilization data for all levels of practitioner.

Additionally, the providers receiving per diem and bundled payments for rehabilitative services such as Mental Health Services Not Otherwise Specified, Psychosocial Rehabilitation Services, and Sexual Offender Treatment are not recognized under Federal statute as providers eligible to receive a direct payment. Since bundled rates are designed to make one payment for a variety of services or practitioners, the payment being made on behalf of a Medicaid qualified practitioner in their employ is not identifiable. A bundled rate does not provide for direct payment to the actual practitioners who would be providing the service and is thus not consistent with the requirements of the statute. With the exception of outpatient hospital and clinic services including services provided in a PRTF, providers recognized to provide non-institutional 1905(a) services are individual practitioners.

We also noted that these services are not defined in the State Plan on Attachment 3.1-A pages 6.b-6c nor are these services identified in the corresponding reimbursement methodology on Attachment 4.19-B pages 6.1-6.2. As such, these services may include component services which may or may not be a covered reimbursable service under the Medicaid Program. Further, it was determined that SCDHHS utilized an all inclusive rate.

It is noted that on June 30, 2008, SCDHHS submitted to CMS State Plan Amendment (SPA) 08-014 in order to revise the SPA language to comply with 1902(a)(30)(A) of the Act. Currently, this SPA is off- the-clock.

RECOMMENDATION

We recommend SCDHHS;

(1) Provide CMS with a corrective action plan for revising SPA 08-014 such that the SPA would contain appropriate language for 3.1-A and 4.19-B pages for rehabilitative services to identify services with language that complies with Federal guidelines and requirements. At a minimum, the unbundled rehabilitative services should be descriptive enough to meet CMS' current definition requirements, including provider qualifications, specific limitations that support proper administration, implementation, and utilization. The SPA should also include an acceptable payment methodology to assure that payments are consistent with efficiency and economy.
Note: CMS may defer future claims on the CMS-64 until this finding is resolved.

State Response

As stated previously, the State has ceased drawing down federal funds for the Therapeutic Behavioral Health Services (High Management, Moderate Management, and Supervised Independent Living) for dates of service on or after January 1, 2009.

Furthermore, the State has begun to transition away from federal funding for Therapeutic Foster Care Services; this process will be done in two stages just as the transition away from the use of federal funds for group care facilities was done in two phases. As indicated in the Medicaid Bulletin dated July 9, 2009, the State reduced the treatment rate for Therapeutic Foster Care Services by 25% on August 1, 2009. The State intends to cease federal reimbursement for Therapeutic Foster Care Services on July 1, 2010.

The State continues to work closely with CMS RO and CO policy and reimbursement staff to revise SPA 08-014 and insure that it contains appropriate language for 3.1-A and 4.19-B for rehabilitative services. Based on guidance received from CMS staff, the State has clearly defined each discrete service, provider qualifications, and reimbursement methodology.

The State intends to submit a completed SPA document to CMS for approval by November 30, 2009. Upon approval from CMS, the State intends to discontinue the services identified on Table III of this report and proposes to implement a system that makes payments to individual providers based on the discrete service being provided and on the qualifications of the practitioner providing the service. The State has been working with public and private providers over the last several years to prepare them for this transition.

CMS Comments

CMS accepts the State's response. On November 30, 2009, we received SPA 09-011, which replaces SPA 08-014. We will work with the State towards an approvable SPA that will resolve this particular issue. We will also monitor claim activity to verify claims for Therapeutic Behavioral Health Services (High Management, Moderate Management, and Supervised Independent Living) have ceased for dates of service on or after January 1, 2009 and that claims will cease for federal reimbursement for Therapeutic Foster Care Services on July 1, 2010 during our quarterly CMS-64 review process.