DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Kost/Chavis	7-10-13

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 000005	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR _____ cc: Mr. Keck, Kost, Deps, CMS file	[X] Prepare reply for appropriate signature DATE DUE 7-19-13 [ ] 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 SERVICES
Centers for Medicare & Medicaid Services
Atlanta Regional Office
61 Forsyth Street, Suite 4T20
Atlanta, Georgia 30303

CENTERS FOR MEDICARE & MEDICAID SERVICES

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

June 18, 2013

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

Attention: Sheila Chavis

RE: State Plan Amendment (SPA) 13-004

Dear Mr. Keck:

We reviewed the proposed amendment submitted under transmittal number SC 13-004. This amendment adds substance abuse outpatient and residential treatment services for adults and children to the South Carolina rehabilitative services benefit and proposes bundled rates for these services. Before we can continue processing this amendment, we need additional or clarifying information. We are requesting additional information as follows:

Attachment 3.1-A, Limitation Supplement

All Rehabilitative Services

1. Please add to the state plan any limitations on amount, duration or scope of services for each of the rehabilitative services. In some instances, the state indicates that a "stay" is "3 – 5" days or that the services are "20 or more" hours per week. Are any of the limitations on amount, duration or scope maximum limitations? The state has advised us that any maximum limitations can be exceeded based on medical necessity, but please also add this information to the state plan for each service or program.

2. Please add to the state plan a brief description of the state's requirements for the agencies and residential treatment programs that make them qualified to furnish the specified rehabilitative services.

Behavioral Health Services

3. The state has added that Psychosocial Rehabilitation Services may be provided individually or in a group. Please describe how this service is delivered in a group and how it is claimed if furnished in a group. Please also explain how this service reduces disability and restores a person to her/his best possible functional level.

4. Does the state consider a "family/caregiver" a provider of Family Support? If so, please more fully describe the role of the family/caregiver and include in the state plan a summary of the state's requirements for this practitioner's qualifications.

Overall Questions re: Residential Substance Abuse Treatment Services

5. Please explain why the Substance Abuse Residential Treatment programs are not reflected in the "qualifications" section of the state plan. If the state intends to claim for these services, then the practitioner qualifications need to be included.

6. The state has not provided sufficient information for us to fully understand the different levels of care that the state proposes to provide in the Residential Substance Abuse Treatment Services programs. In order for CMS to understand whether the services furnished in these residential programs are Medicaid coverable services, please more fully describe in the state plan the American Society of Addition Medicine (ASAM) levels of these facilities and list and describe the rehabilitative services furnished in them.

7. Please list in the state plan the component services for each of the residential substance abuse treatment programs where the state has not yet done that, along with any limitations on those services.

8. What does the state mean when it indicates it is "bundling" services? What services are being "bundled" in the Residential Substance Abuse Treatment Services programs?

9. Please explain how the state ensures free choice of providers in the residential treatment programs. May a beneficiary in need of services in a residential treatment program select the treatment program? May a beneficiary select the practitioners who will furnish the residential services to her/him in the residential treatment program, even if they are not employed by or under contract with the residential treatment program or another entity?

Clinically Managed Residential Detoxification – Level III.2-D

10. Please specify the "appropriately trained staff" that provide "24-hour supervision, observation and support to beneficiaries who are intoxicated or experiencing withdrawal." Are these staff different from the staff who "may supervise self-administered medications for the management of withdrawal?

11. Please explain what a withdrawal assessment is. Is it part of the physical exam?

12. If the stay is typically 3- 5 days, when should the physical exam occur? Please explain why a physical exam is allowed to occur up to 48 hours after admission in a 3 -5 day stay?

13. Please explain how an individualized plan of care and a discharge plan can feasibly be developed during a 3 - 5 day stay in this treatment program.

14. Are any of the state's Behavioral Health services provided in this level? If so, please include in the state plan the Behavioral Health services that will be furnished in this treatment program.

Medically Monitored Detoxification Services - Level III.7-D

15. Please specify in the state plan the "other qualified nursing specialist" that should be present to administer an initial alcohol and drug assessment.

16. We believe there are some typographical errors in the last sentence on page 6c.6.

17. On page 6c.7, the state indicates, "required services and support systems include those listed above". Please specify the intended services and support systems in the state plan.

Clinically - Managed High - Intensity Residential Treatment - Level III.5-R

18. Please specify the "treatment staff" in the state plan.

19. Please specify in the state plan what is intended by the reference to "adequate nursing supervision".

20. Please explain why a stay is longer than "the more intensive medically managed levels of care."

21. On page 6c.7 the state indicates "required services and support systems include those listed above". Please specify the intended services and support systems in the state plan.

22. Please specify in the plan the "qualified professional" staff that will provide 40 hours of clinical services per week.

23. Please specify in the state plan the "clinical services" that will be furnished.

24. Please specify in the state plan the "coverage" and "services" that "residential staff" will furnish. Also, please specify in the state plan the "residential staff".

Medically-Monitored Residential Acute Treatment – Level III.7 – B

25. Please clarify the meaning of the second sentence in the state plan, "The beneficiaries of this service have functional deficits in the withdrawal, bio-medical and/or emotional, medical, and/or cognitive domains that interfere with or distract from recovery efforts."

26. Please summarize in the state plan the "ASAM medical necessity criteria."

27. On page 6c.7, the state indicates, "required services and support systems include those listed above". Please specify the intended services and support systems in the state plan.

Medically-Monitored High-Intensity Adolescent Residential Treatment – Level III.7-RA

28. It appears that the state is restricting this service to a subpopulation of the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) population which is a comparability violation. Please either delete the service, or modify it so that any child under age 21 can receive the service.

29. Please specify in the state plan the component services that will be furnished in this treatment program.

30. On page 6c.8, the state indicates, "required services and support systems include those listed above". Please specify the intended services and support systems in the state plan.

31. Please clarify this language in the state plan, "Note: Will differentiate between adolescent (under age 21) and adult through the use of a modifier (HA)".

Day Treatment/Partial Hospitalization – Level II.5

32. Please specify in the state plan the component services that will be furnished in this program.

33. Please clarify in the state plan the meaning of "beneficiaries who are in need of more than traditional intensive outpatient treatment services or as an alternative to residential treatment" in the state plan.

Intensive Outpatient Treatment Program – Level II.1

34. Please specify in the state plan the component services that will be furnished in this program.

35. Please clarify in the state plan the meaning of "beneficiaries who are in need of services beyond the scope of traditional intensive outpatient treatment services or as an alternative to residential treatment".

36. Please explain how this service is different than Day Treatment.

Rehabilitative Services for Primary Care Enhancement

37. Please explain in the state plan what this service is, what the component services are, who the provider entities and practitioners are who furnish this service, what their qualifications are, and how the service is different from other Rehabilitative Services. Please also include in the state plan all settings in which Primary Care Enhancement can be furnished. Finally, please indicate whether the physicians that furnish this service are employees of the provider entities that furnish this service.

38. We notice several discrepancies between service titles in the reimbursement and coverage pages:

a. Is "Group Psychotherapy" the same as "Group Therapy" which is on page 6c.1 of Attachment 3.1-A Limitation Supplement? Please revise the name of this service so they are consistent in the plan pages if they are the same service.

b. Please describe "Vivitrol Injection" and explain why it is not included as part of Medication Administration.

c. "Medication Administration" does not appear on the coverage pages. If it is the state's intention to include this as a covered rehabilitative service, please add it as a service in the coverage pages, along with a service description, the providers and practitioners who furnish the service, provider and practitioner qualifications and any limitations on amount, duration and scope of the service.

d. Please revise the plan pages so that the following service names listed on page 6.1e.c or on page 6.1e.d of Attachment 4.19-B are consistent with the services in the coverage pages. If the state has to add a service to the coverage page, the state plan must include a service description, the providers and practitioners that furnish the service, the provider and practitioner qualifications, and any limitations on amount, duration and scope of the service.

- "Psychiatric Diagnostic Evaluation with Medical Services";
- "Psychological Testing/Diagnostic Assessment";
- "Alcohol and Drug Assessment";
- "Alcohol and Drug – Nursing Services";
- "Alcohol and/or Substance Abuse Structured Screening and Brief Intervention Services";
- "Individual Psychotherapy";
- "Substance Abuse Counseling –Group";
- "Skills Training and Development Service – 0 to 6 years of age";
- "Family Psychotherapy".

39. What types of services are intended when the state references "outpatient" services? Please clarify if the state is referring to outpatient hospital services or community-based rehabilitative services.

Attachment 4.19-B Plan Pages

40. Form HCFA-179, box 7 – The state reported $3,000,000 Federal budget impact for FFY 13 and $4,500,000 for FFY 14. Please provide us with the information the state used, and calculations, for the estimated budget impact and confirm that costs related to Room and Board and Managed Care are excluded.

41. Please provide a copy of the inter government transfer (IGT) agreement.

Page 6.1e – Paragraph 1:

42. As the state is transitioning from a cost finding methodology to a cost-based rate, it appears the language in the first paragraph is no longer needed. Does the state plan, however, include considerations for overhead/indirect costs in the computation of the cost-based rate? If so, please revise this paragraph to further explain how the state will allow providers to recognize overhead/indirect costs as it directly pertains to the furnishing of the Medicaid-allowed Alcohol and Drug Abuse Services. If the state does not include considerations for overhead/indirect costs in the computation of the cost-based rate, this paragraph should be removed in its entirety.

Page 6.1e – Paragraphs 2 - 5:

43. As the state is transitioning from a cost finding methodology to a cost-based rate, it appears the language in paragraphs two - five is no longer needed. Please delete this language if our understanding is correct.

Page 6.1e.a:

44. This section discusses the type of setting. Please provide a detailed listing of each type of setting. Please also amend this section to indicate that room and board are not considered in the construct of the rate(s) paid in each setting.

45. Please provide a copy of the South Carolina Department of Alcohol and Other Drug Abuse Services 2010 cost report.

46. Please provide an indication of whether this methodology is applicable to private, state-owned and non-state government owned providers of alcohol and drug abuse services.

47. The procedure codes and the successor codes may be subject to change. Please include in the state plan a link to a state website which providers can access to find the current codes. If these codes are updated annually, the state can use language indicating the codes are the most recent and are updated annually.

48. With regard to the table on page 6.1e.a, please elaborate as to how these services are bundled. CMS has historically determined that payment for a service is bundled if any of the following scenarios are presented:

- One billable unit of service consists of multiple Section 1905(a) services/activities. For example if one billable unit consisted of Day Treatment/Partial Hospitalization as well as Social Detoxification, the rate used to pay for the service would be bundled.
- One billable unit is claimed when more than one type of practitioner provides one or more services to either one individual or a group of individuals at the same time.

49. The paragraph that immediately follows the table notes that the methodology is based on 2010 cost reports. Per a conference call in Mid-April, the state indicated that it would be reasonable to update the basis for the cost report every three years. Please add language to this paragraph to indicate that the basis for the cost-based rate will be updated every three years.

Page 6.1e.b:

50. The sixth paragraph on this page discusses Administrative/Overhead Costs. Please elaborate as to how "indirect cost" is recognized. Does the state use a cognizant agency indirect rate to recognize indirect cost or is the recognition of indirect cost governed by a Cost Allocation Plan?

Page 6.1e.c:

51. Please elaborate as to the inclusion of the table on this page. Are the descriptions within this table a subset of the activities listed in the table on page 6.1e.a?

52. The procedure codes and the successor codes may be subject to change. Please include in the state plan a link to a website which providers can access to find the current codes. If these codes are updated annually, the state can use language indicating the codes are the most recent and are updated annually.

Page 6.1e.d:

53. Please elaborate as to the inclusion of the table on this page. Are the descriptions within this table a subset of the activities listed in the table on page 6.1e.a?

54. The procedure codes and the successor codes may be subject to change. Please include in the state plan a link to a website which providers can access to find the current codes. If these codes are updated annually, the state can use language indicating the codes are the most recent and are updated annually.

Page 6.1f:

55. This section discusses Primary Care Enhancement. Please include the services that are included under the general heading of Primary Care Enhancements.

56. The procedure codes and the successor codes may be subject to change. Please include in the state plan a link to a website which providers can access to find the current codes. If these codes are updated annually, the state can use language indicating the codes are the most recent and are updated annually.

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, which would have expired on June 27, 2013. 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.

We ask that you respond to this RAI via the Atlanta Regional Office SPA/Waiver e-mail address at SPA_Waivers_Atlanta_R04@cms.hhs.gov. The original signed response should also be sent to the Atlanta Regional Office.

If you have any questions, please contact either Maria Drake at (404) 562-3697 or Cheryl Wigfall at (803) 252-7299.

Sincerely,

Jackie Glaze

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

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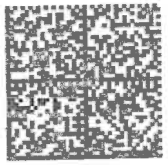

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