DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

*Note...need due date & logged to Singleton.

TO	DATE
Singleton	10-17-11

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 10-164	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR _____ CC: Mr. Keck, Depo, CMS file, Williams, Hutto Cleared 11/16/11, letter attached.	[X] Prepare reply for appropriate signature DATE DUE 11-15-11
	[ ] 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.			Demo 72
3.			T2E
4.			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Hess	10-17-11

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 10-164	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR CC: Mr. Keck, Deps, CMS file	[ ] 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.			

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

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: South Carolina Title XIX State Plan Amendment (SPA), Transmittal #11-011

Dear Mr. Keck:

South Carolina submitted State Plan Amendment (SPA) 11-011 which was received by the Centers for Medicare and Medicaid Services (CMS) on July 14, 2011. This SPA proposes to reduce provider payments by various percentages based on service. This reduction is in addition to the 3 percent reduction on April 8, 2011. SC is making these changes to maintain expenditures within the budget appropriations for State Fiscal Year 2012 effective for services provided on or and after April 4, 2011 by reimbursing providers at 97 percent of the Medicaid rate or Medicaid payment calculated in accordance with the methodologies in effect on April 1, 2011.

We conducted our review of South Carolina SPA 11-011 according to Federal regulations. Based on our previous conversations, before we can continue processing this SPA, we are requesting additional information as follows:

Reimbursement (Access of Care)
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.

1. 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.
2. 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.

3. 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?
4. How often (i.e. frequency) does the South Carolina Department of Health and Human Services review the reports/measures it uses to monitor access?

Pharmacy Reimbursement Methodology

Attachment 4.19-B, Page 3b, Section 12.a, Prescribed Drugs

1. In accordance with long standing requirements of Federal regulations presently codified at 42 CFR 447.512 provide that payments for drugs are to be based on the ingredient and a reasonable dispensing fee. In addition, States establish their reimbursement methodologies for the ingredient cost of a drug using the EAC of that drug. The definition of EAC, codified at 42 CFR 447.502, is "the agency's best estimate of the price generally and currently paid by providers for a drug marketed or sold by a particular manufacturer or labeler in the package size of the drug most frequently purchased by providers. Please describe the State's rationale and provide the documentation for how the State determined that the proposed reimbursement change from AWP minus 13 percent to AWP minus 16 percent for the ingredient cost is in accordance with these requirements.

2. In addition, please describe the State's rationale and provide the documentation for how the State's proposed reduction from $4.50 to $3.00 for the dispensing fee complies with these requirements.

We are requesting this additional/clarifying information under provisions of section 1915(f)(2) 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 October 12, 2011. 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.

If you have any questions or need any further assistance, please contact Yvette Moore at (404) 562-7327. For any pharmacy reimbursement questions, please contact Tandra Hodges at (404) 562-7409.

Sincerely,

Jackie Glaze

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

* This supersedes Log # 164 w/additional information. cc: Mr. Keck Dept Custile Sayon Williams

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

CMS CENTERS for MEDICARE & MEDICAID SERVICES

Ref. Log # 164

October 18, 2011

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

RE: Amended Request: South Carolina Title XIX State Plan Amendment (SPA), Transmittal #11-011

Dear Mr. Keck:

South Carolina submitted State Plan Amendment (SPA) 11-011 which was received by the Centers for Medicare and Medicaid Services (CMS) on July 14, 2011. This SPA proposes to reduce provider payments by various percentages based on service. This reduction is in addition to the 3 percent reduction on April 8, 2011. SC is making these changes to maintain expenditures within the budget appropriations for State Fiscal Year 2012 effective for services provided on or and after April 4, 2011 by reimbursing providers at 97 percent of the Medicaid rate or Medicaid payment calculated in accordance with the methodologies in effect on April 1, 2011.

We conducted our review of South Carolina SPA 11-011 according to Federal regulations. Based on our previous conversations, before we can continue processing this SPA, we are requesting additional information as follows:

Reimbursement (Access of Care)
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.

1. 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.

2. 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.
3. 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?
4. How often (i.e. frequency) does the SCDHHS review the reports/measures it uses to monitor access?

Maintenance of Effort (MOE)

1. Under section 1902(gg) of the Social Security Act (the Act), as amended by the Affordable Care Act, as a condition of receiving any Federal payments under the Medicaid program during the MOE period indicated below, the State shall not have in effect any eligibility standards, methodologies, or procedures in its Medicaid program which are more restrictive than such eligibility provisions as in effect in its Medicaid program on March 10, 2010.

   MOE Period.
   § Begins on: March 10, 2010, and
   § Ends on: The date the Secretary of the Federal Department of Health and Human Services determines an Exchange established by a State under the provisions of section 1311 of the Affordable Care Act is fully operational.

   Is SC in compliance with the conditions of the MOE provision of section 1902(gg) of the Act for continued funding under the Medicaid program?

2. Section 1905(y) and (z) of the Act provides for increased federal medical assistance percentages (FMAP) for expenditures made on or after January 1, 2014 for individuals determined eligible under section 1902(a)(10)(A)(i)(VIII) of the Act. Under section 1905(cc) of the Act, the increased FMAP under sections 1905(y) and (z) would not be available for States that require local political subdivisions to contribute amounts toward the non-Federal share of the State's expenditures at a greater percentage than would have been required on December 31, 2009.

   Prior to January 1, 2014 States may potentially require contributions by local political subdivisions toward the non-Federal share of the States' expenditures at percentages greater than were required on December 31, 2009. However, because of the provisions of section 1905(cc) of the Act, it is important to determine and document/flag any SPAs/State plans which have such greater percentages prior to the January 1, 2014 date in order to anticipate potential violations and/or appropriate corrective actions by the States and the Federal government.

This SPA would [ ] / would not [ ] violate these provisions, if they remained in effect on or after January 1, 2014.

3. Section 1905(aa) of the Act provides for a "disaster-recovery FMAP" increase effective no earlier than January 1, 2011. Under section 1905(cc) of the Act, the increased FMAP under section 1905(aa) of the Act is not available for States that require local political subdivisions to contribute amounts toward the non-Federal share of the State's expenditures at a greater percentage than would have been required on December 31, 2009.

   This SPA qualifies for such increased federal financial participation (FFP) and is not in violation of this requirement.

4. Does SC 11-011 comply with the requirements of section 1902(a)(37) of the Act regarding prompt payment of claims?

Pharmacy Reimbursement Methodology

Attachment 4.19-B, Page 3b, Section 12.a, Prescribed Drugs

1. In accordance with long standing requirements of Federal regulations presently codified at 42 CFR 447.512 provide that payments for drugs are to be based on the ingredient and a reasonable dispensing fee. In addition, States establish their reimbursement methodologies for the ingredient cost of a drug using the EAC of that drug. The definition of EAC, codified at 42 CFR 447.502, is "the agency's best estimate of the price generally and currently paid by providers for a drug marketed or sold by a particular manufacturer or labeler in the package size of the drug most frequently purchased by providers. Please describe the State's rationale and provide the documentation for how the State determined that the proposed reimbursement change from AWP minus 13 percent to AWP minus 16 percent for the ingredient cost is in accordance with these requirements.

2. In addition, please describe the State's rationale and provide the documentation for how the State's proposed reduction from $4.50 to $3.00 for the dispensing fee complies with these requirements.

We are requesting this additional/clarifying information under provisions of section 1915(f)(2) 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 October 12, 2011. 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.

If you have any questions or need any further assistance, please contact Yvette Moore at (404) 562-7327. For any pharmacy reimbursement questions, please contact Tandra Hodges at (404)562-7409.

Sincerely,

Jackie Glaze

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

Enclosure

Reg #000164

South Carolina Department of
Health & Human Services

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

November 16, 2011

Ms. Jackie Glaze
Associate Regional Administrator
Division of Medicaid and Children's Health Operations
Centers for Medicare and Medicaid Services – Region IV
61 Forsyth Street, SW, Suite 4T20
Atlanta, Georgia 30303-8909

RE: Amended Request: South Carolina Title XIX State Plan Amendment (SPA), Transmittal # SC 11-011

Dear Ms. Glaze:

This is in response to your request for additional/clarifying information regarding the above-referenced SPA. Please find the South Carolina Department of Health and Human Services' (SCDHHS) responses to your requests below:

Reimbursement (Access of Care)

1. 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.

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.

2. 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.

3. 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.

4. 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.

Maintenance of Effort (MOE)

1. Is SC in compliance with the conditions of the MOE provision of section 1902(gg) of the Act for continued funding under the Medicaid program?

Response: Yes.

2. Section 1905(y) and (z) of the Act provides for increased federal medical assistance percentages (FMAP) for expenditures made on or after January 1, 2014 for individuals determined eligible under section 1902(a)(10)(A)(i)(VIII) of the Act. Under section 1905(cc) of the Act, the increased FMAP under sections 1905(y) and (z) would not be available for States that require local political subdivisions to contribute amounts toward the non-Federal share of the State's expenditures at a greater percentage than would have been required on December 31, 2009.

   Prior to January 1, 2014 States may potentially require contributions by local political subdivisions toward the non-Federal share of the States' expenditures at percentages greater than were required on December 31, 2009. However, because of the provisions of section 1905(cc) of the Act, it is important to determine and document/flag any SPAs/State plans which have such greater percentages prior to the January 1, 2014 date in order to anticipate potential violations and/or appropriate corrective actions by the States and the Federal government.

Response: **This SPA would [ ] / would not [X] violate these provisions, if they remained in effect on or after January 1, 2014.**

3. Section 1905(aa) of the Act provides for a "disaster-recovery FMAP" increase effective no earlier than January 1, 2011. Under section 1905(cc) of the Act, the increased FMAP under section 1905(aa) of the Act is not available for States that require local political subdivisions to contribute amounts toward the non-Federal share of the State's expenditures at a greater percentage than would have been required on December 31, 2009.

Response: **This SPA would [X] / would not [ ] qualify for such increased federal financial participation (FFP) and is not in violation of this requirement.**

4. Does SC 11-011 comply with the requirements of section 1902(a)(37) of the Act regarding prompt payment of claims?

Response: **Yes.**

Pharmacy Reimbursement Methodology

Attachment 4.19-B, Page 3b, Section 12.a, Prescribed Drugs

1. In accordance with long standing requirements of Federal regulations presently codified at 42 CFR 447.512 provide that payments for drugs are to be based on the ingredient and a reasonable dispensing fee. In addition, States establish their reimbursement methodologies for the ingredient cost of a drug using the EAC of that drug. The definition of EAC, codified at 42 CFR 447.502, is "the agency's best estimate of the price generally and currently paid by providers for a drug marketed or sold by a particular manufacturer or labeler in the package size of the drug most frequently purchased by providers." Please describe the State's rationale and provide the documentation for how the State determined that the proposed reimbursement change from AWP minus 13 percent to AWP minus 16 percent for the ingredient cost is in accordance with these requirements.

Response: **In determining a pharmacy reimbursement rate that constitutes the best estimate of the price generally and currently paid for drugs, SC DHHS evaluated prescription drug reimbursement from a number of sources.**

1. Published Surveys. Two recently published surveys have established estimates of pharmacy reimbursement by various payer types. While this sort of analysis does not measure the price of pharmaceuticals directly, the market forces that exist to

arrive at these rates create a payment that is consistent with current market prices of the medications, as well as ensuring that access to pharmaceutical products and services remains available to beneficiaries.

The *Pharmacy Benefit Report* published by Novartis looked to evaluate the AWP discount applied by various groups of payers. The findings of that analysis are included in the table below.

Payer Type	Average AWP Offset	AWP Range
Commercial/Group	15.9 %	12%-22%
Managed Medicaid	15.6%	14%-17%
Medicare Advantage Part D	15.8%	13%-17%
Stand Alone PDP	16%	14%-17%
State of Alabama	AAC	
State of Tennessee	16%	13%-16%

***Average Acquisition Cost (AAC)

In the *2010-2011 Prescription Drug Benefit Cost and Plan Design Report*, the AWP discount percentage was found to be 17.5%. This particular report included only commercial payers, most of whom have the ability to reimburse at lower rates through the ability to more aggressively manage the size of their provider network. We also did a comparative analysis of our proposed reimbursement methodology to Alabama's Average Acquisition Cost (AAC) methodology. We compared about 290 drugs and determined that our over all variance with the proposed methodology change to Alabama was only 0.58%.

- Armed with these national estimates and other state plan comparisons, SC DHHS staff then consulted with other prescription drug payers in the State, including the Medicaid Managed Care plans, and it was determined that the best estimate of the price generally and currently paid by providers for medication in South Carolina is AWP minus 16%. Also, providers were given an opportunity to participate in helping DHHS take cost out of the system to address the budget deficit. The

agency held stakeholder meetings where providers brought saving ideas, plans, and suggestions of ways to address the deficit without just utilizing budget cuts. Numerous meetings were held with the Pharmacy Associations, Chain Store Associations and others as we looked for ways to reduce costs. After these meeting a number of methods were agreed on to assist with reducing the budget including the rate reduction that is outlined in this state plan.

2. In addition, please describe the State's rationale and provide the documentation for how the State's proposed reduction from $4.50 to $3.00 for the dispensing fee complies with these requirements.

Response: **To determine the dispensing fee that should accompany the AWP minus 16% rate, SC DHHS turned to the AAC pricing data currently available from the Alabama Medicaid pharmacy program. Taking a sample of the medications that constitute the most expensive for the SC Medicaid program, SC DHHS calculated that, in aggregate, the Alabama AAC plus the Alabama Dispensing Fee equals AWP minus 16% plus the SC Dispensing Fee. Based on this calculation, AWP minus 16% plus $3.00 was found to be equivalent to the current Alabama reimbursement. Also we compared our reimbursement to other states and AWP minus 16% plus a $3.00 dispensing fee is comparable to the State of Tennessee.**

It should be noted that using the Alabama system as a comparison in the determination of the dispensing fee ensures that total reimbursement for SC Medicaid pharmacy claims (ingredient cost plus dispensing fee), is consistent with the total reimbursement determined by Alabama through pharmacy invoicing and cost of dispensing study.

We trust this response addresses all the issues raised in CMS' RAI. Please contact Deirdra T. Singleton at (803) 898-2647, if you have any questions regarding this matter.

Sincerely,

Anthony E. Keck
Director

AEK/sb
Enclosures