DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Singleton/FOIA	7-1-08

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 080062	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR _____ cc: Ms. Forkner, Myers	[ ] Prepare reply for appropriate signature DATE DUE _____ [X] FOIA DATE DUE 7-16-08 [ ] Necessary Action

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
1. Cleared 7/22/08 letter attached			
2.			
3.			
4.			

PATRICIA L. HARRISON
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June 30, 2008

Ms. Emma Forkner
SC Department of Health and Human Services
PO Box 8206
Columbia, South Carolina

Dear Emma:

I was disappointed to see that the Medicaid Bulletin which HHS issued on June 17, 2008 did not address the issues identified in my letter dated March 18, 2008 which were contained in the recent CMS regulations related to targeted case management. A copy of my letter is attached. In that letter, I requested notice of any meetings held to discuss the implementation of the new targeted case management regulations issued by CMS. I also requested copies of any further written guidance SCHHS provides to affected agencies and notice of any public hearings and promulgating regulations related to these new requirements. I do not recall receiving notice of any meetings, guidance issued by SCDHHS or scheduled public hearings.

It is my understanding that the new federal regulation was issued because of the concerns of Congress related to improper billing of non-Medicaid services to the Medicaid program by some States, while also including significant beneficiary protections that ensure comprehensive and coordinated services to meet the needs of beneficiaries. The recently issued SCDHHS Medicaid bulletin does not address these Congressional concerns.

SCHHS pays more than $235.00 per month if even one unit of service coordination is provided during the month. The CMS regulations clearly require that the State can only be paid on a fee-for-service basis for targeted case management, not to exceed 15 minutes. SCDHHS does not appear to be in compliance with this requirement in the MR/RD Medicaid waiver program.

I have previously shared my concerns that SCDHHS pays SCDDSN more than double the amount for targeted case management than the amount SCDDSN pays providers of these services. SCDDSN has refused to allow providers of targeted case management to bill SCHHS directly for these services. If I am incorrect, and SCDHHS allows targeted case managers to bill SCDHHS directly for these services, please correct my misunderstanding and provide documentation of the SCDHHS policy that allows these providers to bill Medicaid directly.

CMS clearly instructed the States that service coordinators are intended to assist participants in obtaining services, not to act as "gatekeepers." The CMS template for CMS 2237 IFC states that the State must assure that providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services. Federal law requires

that medical necessity is to be established by the participant's treating physician. If a treating physician determines that a waiver service is medically necessary, Congress requires that the State provide that service - and that the service be provided with reasonable promptness. SCDDSN has historically ignored this requirement and has instructed service coordinators to deny MR/RD Medicaid waiver services, such as adult companion services, in its Service Coordinators Manual. This manual is written by SCDDSN employees. Its policies have not been promulgated as regulations and they conflict with federal law and CMS regulations. Basing the denial of MR/RD Medicaid waiver services on this service coordinator's manual violates CMS's new directives.

The federal regulations also clearly state that the State cannot condition the receipt of Medicaid services upon the receipt of targeted case management. SCDDSN impermissably requires MR/RD Medicaid waiver participants to use a service coordinator.

Where a participant chooses to receive targeted case management services, the new regulations reiterate the requirement that participants have the right to choose from any qualified provider of the service. I have previously shared my concerns with HHS about the lack of choice of providers of service coordination services. Only in recent months has there been any choice of service coordination services for adults with mental retardation living in the Midlands. DDSN has always refused to allow my MR clients living in Richland and Lexington Counties to use any provider other than the Richland Lexington Disabilities and Special Needs Board. Participants cannot even choose to use service coordinators from an adjacent county. Allowing MR/RD Medicaid waiver participants to choose any qualified provider in the State and allowing those providers to bill SCDHHS directly seems to be required by the "freedom of choice" requirements in the new regulation and the Sample Outline contained at

http://www.cms.hhs.gov/DeficitReductionAct/Downloads/CM_SPA_Outline.pdf

At a recent Access to Justice Hearing, one guardian of a MR/RD Medicaid waiver participant complained that even though all of her son's MR/RD waiver services were being provided in Aiken County, because his residence was in Lexington County, he was required to use RichLex for service coordination. She also complained that her son's Medicaid waiver funds were being paid to the Babcock Center, although he was not receiving a single service from the Babcock Center. She told Commission members that this was especially troubling to her because her son was raped while receiving day services at the Babcock Center.

As I discussed in my letter, the new federal regulation is clear that CMS now prohibits "bundled" payments for service coordination:

> **While a State has some flexibility to establish the methodology and rates it will use to reimburse providers of case management or targeted case management services, a State cannot employ a methodology or rate that results in payment for a bundle of services. Per diem rates, weekly rates, and monthly rates represent a bundled payment methodology that is not consistent with section 1902(a)(30)(A) of the Act, which requires that States have methods and procedures to assure that payments are consistent with efficiency, economy, and quality of care. A bundled payment methodology exists when a State pays a single rate for more than one service furnished to an eligible individual during a fixed period of time. The payment is the same regardless of the number of services furnished or the specific costs, or**

otherwise available rates. Since these bundled (daily, weekly, or monthly) rates are not reflective of the actual types or numbers of services provided or the actual costs of providing the services, they are not accurate or reasonable payments and may result in higher payments than would be made on a fee-for-service basis for each individual service. A bundled rate is inconsistent with economy, since the rate is not designed to accurately reflect true costs or reasonable fee-for-service rates, and with efficiency, since it requires substantially more Federal oversight resources to establish the accuracy and reasonableness of State expenditures. We therefore expect that case management and targeted case management services reimbursed on a fee-for-service basis, as opposed to a capitated basis, will be reimbursed based on units of time. Because of the nature of case management, which can include contacts of brief duration, we believe that the most efficient and economical unit of service is a unit of 15 minutes or less. Accordingly, we are requiring in Sec. 441.18(a)(8)(vi) that the unit of service for case management and targeted case management services be 15 minutes or less.

By copy of this letter, I am formally informing the Chairman of the SCDDSN Commission of objections to his agency continuing to bundle targeted case management services and to deny participants' choice of providers. I am requesting that MR/RD Medicaid waiver participants be informed of their right to choose not to use service coordination and to choose from any willing provider of that service. I would appreciate the opportunity to meet with you and Felicity to discuss my concerns. Pursuant to FOIA, I am requesting copies of minutes of any meetings where implementation of the new CMS targeted case management have been discussed. I would also appreciate your providing me with copies of letters or directives SCDHHS has sent to SCDDSN or received from SCDDSN related to the implementation of these new CMS regulations. As always, thank you for your consideration of my concerns and for your prompt response.

Cordially,

Patricia L. Harrison

cc: Jean Close, CMS Baltimore
Governor Mark Sanford
Jane Thesing, LAC
Evelyn McCarthy
Pamela Doty
Suzanne Bosstick
Sen. Lindsey Graham
Rep. James Harrison
Gloria Prevost, P&A
Andre Bauer, Lt. Gov. Office
Deidra Singleton, Esq.
Robert Hamill, Chairman DDSN

South Carolina
DEPARTMENT OF HEALTH AND HUMAN SERVICES
Post Office Box 8206
Columbia, South Carolina 29202-8206
www.dhhs.state.sc.us

June 17, 2008

MEDICAID BULLETIN

HOS-IP-IMD	*08-09*
HOS-IP-RTF	*08-09*
MHRC-ADA	*08-04*
MHRC-COC	*08-02*
MHRC-MHC	*08-04*
MHRC-MRC	*08-02*

TO: **Targeted Case Management Providers (TCM)**

SUBJECT: **Reimbursement for Targeted Case Management Activities**

The purpose of this Bulletin is to notify providers who deliver Targeted Case Management (TCM) to Medicaid beneficiaries in an institutional setting of significant provisions of an Interim Final Rule issued by the Centers for Medicare and Medicaid Services. This interim final rule revises current regulations for the provision of TCM and clarifies when Medicaid reimbursement is available for case management (CM) activities.

TCM/CM includes only services to individuals who are residing in a community setting or transitioning to a community setting following an institutional stay. Providers may only provide case management services to facilitate the transitioning of individuals from institutions to the community. Individuals (except individuals ages 22 to 64 who reside in an institution for mental diseases (IMD) or individuals who are inmates of public institutions) are considered to be transitioning to the community during the last 60 consecutive days of a covered, long-term, institutional stay that is 180 consecutive days or longer in duration. For a covered, short-term, institutional stay of less than 180 consecutive days, individuals may be considered to be transitioning to the community during the last 14 days before discharge. Services rendered during these time frames are considered to be required for the purpose of transitioning individuals with complex, chronic medical needs to the community.

Medicaid reimbursement for TCM/CM provided to individuals transitioning to a community setting following an institutional stay is only available for services rendered during the time frames specified and for the purpose of transitioning an individual to a community setting. Effective **July 1, 2008**, providers may only receive Medicaid reimbursement for case management activities provided to facilitate the transition of individuals from institutions to the community after 1) the date that an individual leaves the institution, 2) is enrolled with the community case management provider, and 3) is receiving medically necessary services in a community setting. Case management activities provided to individuals residing in an intuitional setting for any other purposes and/or beyond the specified times frames are not billable to Medicaid.

Should you have any questions or concerns regarding this Bulletin you may contact your program representative at (803) 898-2565.

/s/

Emma Forkner
Director

EF/mwfj

NOTE: To receive Medicaid bulletins by email, please send an email to bulletin@scdhhs.gov indicating your email address and contact information.
To sign up for Electronic Funds Transfer of your Medicaid payment, please go to the following link for instructions: http://www.scdhhs.gov/dhhsnew/serviceproviders/eft.asp

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March 18, 2008

Ms. Emma Forkner
SC Department of Health and Human Services
PO Box 8206
Columbia, South Carolina

Dear Emma:

Thank you very much for sending me the agenda and handouts from the January 25, 2008 meeting to discuss the CMS targeted case management regulations which became effective on March 3, 2008. Jean Close at CMS in Baltimore confirmed for me the first week in March that the regulations are in effect now. Although the State is not required to comply with the requirement that each Medicaid participant will have only one case manager until 2009, all other requirements of this regulation are now in effect. The Federal Register clearly stated:

> DATES: Effective Date: The effective date of this rule is March 3, 2008.

The regulation is clear that CMS now prohibits "bundled" payments for service coordination:

> **While a State has some flexibility to establish the methodology and rates it will use to reimburse providers of case management or targeted case management services, a State cannot employ a methodology or rate that results in payment for a bundle of services. Per diem rates, weekly rates, and monthly rates represent a bundled payment methodology that is not consistent with section 1902(a)(30)(A) of the Act, which requires that States have methods and procedures to assure that payments are consistent with efficiency, economy, and quality of care. A bundled payment methodology exists when a State pays a single rate for more than one service furnished to an eligible individual during a fixed period of time. The payment is the same regardless of the number of services furnished or the specific costs, or otherwise available rates. Since these bundled (daily, weekly, or monthly) rates are not reflective of the actual types or numbers of services provided or the actual costs of providing the services, they are not accurate or reasonable payments and may result in higher payments than would be made on a fee-for-service basis for each individual service. A bundled rate is inconsistent with economy, since the rate is not designed to accurately reflect true costs or reasonable fee-for-service rates, and with efficiency, since it requires substantially more Federal oversight resources to establish the accuracy and reasonableness of State expenditures. We therefore**

expect that case management and targeted case management services reimbursed on a fee-for-service basis, as opposed to a capitated basis, will be reimbursed based on units of time. Because of the nature of case management, which can include contacts of brief duration, we believe that the most efficient and economical unit of service is a unit of 15 minutes or less. Accordingly, we are requiring in Sec. 441.18(a)(8)(vi) that the unit of service for case management and targeted case management services be 15 minutes or less.

This is a real problem, because SCHHS is currently in violation of this law by paying DDSN more than $235 a month for service coordination (targeted case management) services - whether or not the participant chooses to receive these services. I agree with Sam that implementing the 15 minute billing increments will require systems change, but I believe that you will find that it will be less expensive than the current system SCHHS is funding for service coordination through DDSN, not more expensive. Currently, DDSN pays providers less than half the amount they receive from SCHHS for these services. Why should SCHHS continue to pay $235 a month if a service coordinator spends as little as15 minutes on a DDSN consumer in a month? SCHHS is ultimately responsible for how Medicaid services are provided and SCHHS already has a template with the way CLTC service coordination is performed, it would seem logical to have the service coordination services contracted directly by SCHHS.

I also hope that SCHHS will pay close attention to the importance CMS has placed on the right to choose from any service coordination provider in the state. DDSN has refused, in most cases, to allow service coordinators in one county to serve individuals who live in another county. They require each provider to submit a separate application to be a provider for each county served. This has greatly restricted the choice of provider guaranteed by 42 U.S.C. 1396a(a)(23). For example, in Richland and Lexington Counties, the only "choice" of service coordination providers for adults with MR is RichLex DSN Board. MR/RD Medicaid waiver participants living in Richland County are not allowed to "choose" to have Kershaw County DSN Board provide their service coordination. There is no competition from private providers of service coordination for adult participants in the MR/RD Medicaid waiver because DDSN has refused to allow providers to bill SCHHS for these services. (Walker and Associates and S.C. Autism Society are the only exceptions. S.C. Autism only provides service coordination for persons who have autism.)

A participant's right to refuse to receive targeted case management services is in effect now and I have advised clients that as of March 3rd, they have the legal right to tell their service coordinator to take a walk. All MR/RD and HASCI Medicaid waiver participants should be told they now have this option, since they are currently being informed that they have to use a DDSN service coordinator. This is especially troubling because DDSN, as discussed above, restricts one's choice of a service coordinator to an employee of the local DSN Board - which is allowed to retain the "unused" Medicaid funds when services are denied. (For adults with mental retardation.) Just like services provided under "regular" Medicaid, if a covered waiver service is determined to be medically necessary by a treating physician, the state is obligated to provide these covered services. This does not require a service coordinator, just a prescription from the doctor.

The new rules prohibit service coordinators from making LOC determinations. Instead of it costing more money to take LOC (level of care) responsibility away from DDSN, complying with this federal requirement that service coordinators no longer perform LOC evaluations also should cost SCHHS significantly less, not more. Federal law clearly provides that Social Security determinations of disability are binding on the State. That makes it easy. If Social Security says a person has a bipolar disorder, it is not necessary for DMH to make another finding. Same with DDSN. If SCHHS or Social Security has already paid VR to make a determination that a person has a severe disability in a category they serve (MR, related disabilities or head/spinal cord injury), that is the end of the questioning as to whether the person has the disability SSA says he/she has. Why do we need a cadre of non-licensed state employees second guessing SSA at taxpayer expense?

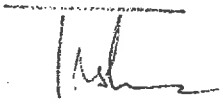
Social Security determinations of disability are binding on SCHHS. SCHHS has a contract with VR already to do these evaluations. SCHHS is spending huge amounts of money unnecessarily paying people who are not even licensed psychologists - in most cases school psychologists - to determine whether individuals have mental retardation or a related disability. Michelle Ford, who oversaw this system has recently left DDSN and her position is vacant. At present, DDSN, DMH and SCHHS determinations of disability on the same individual conflict. Not only is this a money saving opportunity, but it is an opportunity for SCHHS to take responsibility for making sure that federal eligibility laws are followed.

There is no doubt that DDSN service coordinators have been used in SC as "gatekeepers" to keep waiver participants from receiving services. This is now prohibited by CMS. When DDSN service coordinators deny services, their employer (in most cases the local DSN Board) are allowed to retain the Medicaid funds that are not spent providing services. This is a clear conflict of interest. By requiring implementation by March 4, CMS sent a strong message that this is no longer allowable.

I am requesting notice of any meetings held to discuss the implementation of this new regulation and copies of any further written guidance SCHHS provides to affected agencies. Will HHS be holding public hearings and promulgating regulations related to these new requirements. (Whether or not state regulations are promulgated, the agency is required to enforce the federal regulation.) From what I am hearing coming from local DSN boards, they are being told that the 15 minute requirements will not be implemented any time in the near future. I hope that HHS, as the single state agency responsible for the administration of the MR/RD Medicaid waiver program, will provide the local boards with proper advice on the requirements of the new law.

Thank you again for responding to my request and keeping me informed about the progress of your agency's implementation of these regulations.

Cordially,



Patricia L. Harrison

cc: Jean Close, CMS Baltimore
Jane Thesing, LAC
Gloria Prevost, P&A
Curtis Loftis, Lt. Gov. Office

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

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2. DATE SIGNED BY DIRECTOR _____ *Note - For Ms. Forkner's Sign. cc: Ms. Forkner, Myers	[ ] Prepare reply for appropriate signature DATE DUE _____
	[X] FOIA DATE DUE 7-16-08
	[ ] 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.			

Log # 2

State of South Carolina
Department of Health and Human Services

Mark Sanford
Governor

Emma Forkner
Director

July 22, 2008

Patricia L. Harrison, Esquire
Attorney at Law
611 Holly Street
Columbia, South Carolina 29205

RE: Freedom of Information Act Request

Dear Ms. Harrison:

Your June 30, 2008, letter to Ms. Forkner was forwarded to this Office for a response. Thank you for your interest in these matters and your thoughts regarding the new regulations and current situation.

As to your request for copies of minutes of meetings in which implementation of the targeted case management regulations was discussed and correspondence between this agency and the South Carolina Department of Disabilities and Special Needs, we are in the process of gathering the information. We will keep you informed of our progress and provide you a final response once any responsive documents have been identified and gathered.

If you have any questions or I can be of any assistance, please contact me directly at (803) 898-2793 or by e-mail at carterbd@scdhhs.gov.

Sincerely,

Bruce D. Carter
Assistant General Counsel

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