DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Singleton	1-23-12

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 10-283	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR cc: Mr. Keck, Dep0, CMS file	[X] Prepare reply for appropriate signature DATE DUE 3-2-12 [ ] 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
61 Forsyth Street, Suite 4T20
Atlanta, Georgia 30303

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

January 18, 2012

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

RE: State Plan Amendment (SPA) 11-022

Dear Mr. Keck:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 11-022. Effective October 1, 2011 this amendment proposes to revise the inpatient hospital reimbursement methodology for determining payment rates. Specifically, supplemental payments will be made to qualifying private hospitals who are affiliated with a state or unit of local government with a Low Income Needy Patient Care Collaboration Agreement.

We conducted our review of your submittal according to the statutory requirements at sections, 1902(a), 1902(a)(13), 1902(a)(30), 1903(a) and 1923 of the Social Security Act and the regulations at 42 CFR 447 Subpart C. Before we can continue processing this amendment, we need additional or clarifying information.

The regulation at 42 CFR 447.252(b) requires that the State plan include a comprehensive description of the methods and standards used to set payment rates. Section 6002 of the State Medicaid Manual explains further that the State plan must be comprehensive enough to determine the required level of FFP and to allow interested parties to understand the rate setting process and the items and services that are paid through these rates. Further, since the plan is the basis for Federal financial participation, it is important that the plan's language be clear and unambiguous. Therefore, we have the following additional questions/concerns regarding TN 11-022.

1. Public Process. Please provide information demonstrating that the changes proposed in SPA 11-022 comport with public process requirements at section 1902(a)(13)(A) of the Social Security Act and guidance identified in the State Medicaid Director letter issued on December 10, 1997.

2. CMS Form 179 - Box 7. Please provide your detailed analysis of the estimated federal fiscal impact for the applicable Federal Fiscal Years.

3. Please describe the source of the state matching funds for this agreement. If the funds will be from intergovernmental transfers from local governments please provide a copy of the agreements that each local government will enter into with the state or documents that bind them to participate and provide the state matching funds.

4. Upper Payment Limit (UPL) Demonstration – Regulations at 42 CFR 447.272 require that payments in the aggregate will not exceed a reasonable estimate of what Medicare would pay for similar services. Please provide the UPL demonstration applicable to the current rate year for all classes (state government, non-state government, private) of hospitals that are affected by this amendment. The UPL demonstrations should include a comprehensive, step by step, narrative description of the methodology used to determine the UPL. The demonstration should also include a spreadsheet with provider specific information that starts with the source data and identifies the numerical result of each step of the UPL calculation. All source data should be clearly referenced (i.e., cost report year, W/S line and column, claims reports, source of inflation factors, etc) in the demonstration. The State should also keep all source documentation on file for review.

5. Page 25, Section II, 10, J. This section has been amended to include language that acute care hospitals that qualify for DSH shall have the supplemental payments provided for in this amendment exempt from the retrospective hospital cost settlement. As written the amendment cannot be approved. The final disproportionate share hospital regulation at 42CFR 447.299(c)(9) requires that all Medicaid payments received by a provider must be offset in determining the uncompensated care cost for services provided to Medicaid and uninsured patients. Please remove this language from the amendment.

6. Page 26b, Section V.O.1. Qualifying Criteria. This section provides the criteria to determine the providers that qualify for the supplemental payments. To qualify the hospital must be affiliated with a state or unit of local government through a Low Income and Needy Patient Care Collaboration Agreement and be a hospital operated by a private entity. To assist with our review please provide a list by name of each provider and state or unit of local government that will participate in the Collaboration Agreements, a copy of the agreement and the Hospital Certification of Participation Agreement. In addition, please provide a copy of the State Statute or Regulations that define private hospitals and state or units of local government. Also, please provide the criteria used to determine Low Income and Needy patients and how they are different than the criteria used to determine Medicaid and Uninsured patients eligibility.

7. Page 26b, Section V.O.1. Reimbursement Methodology. This section describes the method to be utilized to calculate the Medicare upper payment limit (UPL) as the lesser of the difference between the hospital's Medicaid inpatient billed charges and the Medicaid payments including any Medicaid inpatient cost settlements or the difference between the hospital's specific DSH limit and the hospital's DSH payments during the State Plan Rate Year. Neither one of these methods are acceptable for the determination of what Medicare would pay for these services provided to Medicaid recipients.

   42CFR447.252 provides for the determination of the Medicare UPL based on a reasonable estimate of what Medicare would pay for these services. The methods

acceptable for determining this estimate are (i) cost based on Medicare cost principles, or (ii) based on the Medicare prospective payment system, such as, per discharge payments adjusted for difference in acuity or diagnosis related groups. Please submit an acceptable methodology for estimating the UPL.

The following questions are being asked and should be answered in relation to all payments made to all providers under Attachment 4.19-A of your State plan.

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

9. Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state share of each type of Medicaid payment (normal per diem, supplemental, enhanced, other) is funded. Please describe whether the state share is from appropriations from the legislature to the Medicaid agency, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either an IGT or CPE. In this case, please identify the agency to which the funds are appropriated. Please provide an estimate of total expenditure and State share amounts for each type of Medicaid payment. If any of the non-federal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the state agency receives the transferred amounts from the local government entity transferring the funds. If CPEs are used, please describe the methodology used by the state to verify that the total expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b). For any payment funded by CPEs or IGTs, please provide the following:

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

10. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan. If

supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.

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

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

The Patient Protection and Affordable Care Act (PL 111-148) imposes certain requirements that can impact federal financial participation in a State's Medicaid program:

13. Under section 1902(gg) of 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?

14. 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.

15. 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 would [ ] / would not [ ] qualify for such increased federal financial participation (FFP) and is not in violation of this requirement.

16. Does TN 11-022 comply with the requirements of section 1902(a)(37) of the Act regarding prompt payment of claims?

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. 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.

Please submit your response to:

National Institutional Reimbursement Team
Attention: Mark Cooley
CMS, CMSO
7500 Security Boulevard, M/S S3-14-28
Baltimore, MD 21244-1850

If you have any questions or would like to discuss our comments and questions, please contact Stanley Fields at 502-223-5332.

Sincerely,

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

Cc:

Venesa Day, CMCS
Sheri Gaskins, CMCS
Mark Cooley, CMCS
Stanley Fields, NIRT
Anna Dubois, NIRT
Tim Weidler, NIRT
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