DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Singleton/Chavis	6/18/14

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 000134	[✓] Prepare reply for the Director's signature DATE DUE 3/6/15
2. DATE SIGNED BY DIRECTOR CC: Deps, Kost	[ ] Prepare reply for appropriate signature DATE DUE [ ] 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

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIO

Singleton / Chavis -
C: Deps
Roth

December 4, 2014

Mr. Christian L. Soura
Interim Director
SC Department of Health and Human Services
P.O. Box 8206
Columbia, South Carolina 29202-8206

RE: State Plan Amendment (SPA) 14-015

Dear Mr. Soura:

We have reviewed the proposed amendment to Attachments 4.19-A of your Medicaid state plan submitted under transmittal number (TN) 14-015. Effective July 1, 2014 this amendment modifies the state's reimbursement methodology for setting payment rates for inpatient hospital services. Specifically, this amendment will make the following changes: cap the hospital per discharge rate at the 75th percentile of the October 1, 2013 rate for general acute and short term psychiatric hospitals, hospitals per discharge rate that falls below the 10th percentile will be reimbursed at the 10th percentile, the rate cap will also apply to hospitals eligible for retrospective cost settlement, and creates a prospective per diem payment methodology for free standing rehabilitation hospitals.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a), and 1923 of the Social Security Act (the 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 federal financial participation (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 FFP, it is important that the plan's language be clear and unambiguous. Therefore, we have the following additional questions/concerns regarding TN 14-015:

GENERAL

1. The state estimates a federal budget impact of ($670,415) for FY 2014 and ($2,684,320) FY 2015. Please provide a detailed analysis showing how the state determined the federal budget impact.

2. To assist with our review provide an analysis that identifies by provider the percentile of the base rate component. Also include in the analysis by provider the total estimated Medicaid cost and what percentage of cost will be reimbursed based on the new base rate.

3. Page 17-this section includes the trend rates that will be applied to the per diem rate for rehabilitation hospitals. Please provide the source documents these percentages were obtained from.

4. Page 24-this section is not clear for providers below the 10th percentile and eligibility to receive cost settlement. Will providers be paid their actual allowable cost or up to the Medicare UPL?

5. Pending SPA SC 14-015 revises material that is currently pending in SPAs SC 12-014, 12-024, 13-021, 13-023, and 13-024. We cannot take action on SC 14-015 until all our concerns for the previous amendments are resolved. In addition, any changes made to the current pending SPAs should be included in SC 14-015.

ACCESS to CARE QUESTIONS

Given the effect of provider rate reductions that were implemented with the implementation of a weighted statewide average proposed by this amendment, CMS has concerns that access to care or quality of care could be negatively impacted. As such, please provide responses to the following questions regarding the state's compliance with section 1902(a)(30)(A) of the Social Security Act as it specifically relates to the reductions proposed via TN 14-015.

In general, CMS would like the State in its access responses to address three fundamental issues: 1) the manner in which providers were actively engaged in, and had an impact on, the nature of the cuts; 2) the impact on beneficiary utilization of the cuts and; 3) the state's plans to monitor and address the impact of the cuts on beneficiary access to services or the quality of care. The following questions should be used as appropriate to elicit this information from the state.

6. How did the state determine that the Medicaid provider payments are sufficient to enlist enough providers to assure access to care and services in Medicaid at least to the extent that care and services are available to the general population in the geographic area?

7. What types of studies or surveys were conducted or used by the state to assure that access would not be negatively impacted? Please summarize the findings, the date the study was conducted, and the age of the data. Examples of data that might be studied include:

- Proposed rates as compared to commercial rates, Medicare rates, or rates in other states
- Total number of providers by type and geographic location
- Total number of participating Medicaid providers by type and geographic area
- Percentage of participating Medicaid providers accepting new patients
- Total number of Medicaid Beneficiaries by eligibility type
- Utilization of services by eligibility type over time

8. How were providers, advocates and beneficiaries engaged in the discussion around rate modifications? What were their concerns and how did the state address those concerns? Was there any direct communication (bulletins, town hall meetings, etc.) between the state and providers regarding the reductions proposed by this amendment?

9. Did the state receive any feedback or complaints from the public regarding this rate reduction? If so, how were the complaints addressed and resolved?

10. What types of mechanisms does the state have in place for beneficiaries to raise access issues to the Medicaid agency?

11. Is the State modifying anything else in the State plan which will counterbalance the impact on access that may be caused by the decrease in rates (e.g. increasing scope of services that other provider types may provide or providing care in other settings)?

12. Does the state have a plan to monitor the impact of the new rates and implement a remedy should a problem arise with access? Provide specific details about the measures to be used, how these measures were developed, data sources, and plans for reporting, tracking and monitoring. What are the specific benchmarks for each measure that would indicate access problems?

13. Does the State monitor the number of providers who no longer accept additional Medicaid patients? If yes, please provide data on the number of providers by geographic service area and by quarter that no longer accept Medicaid patients over the last year or as a result of the pending reduction.

14. Does the State require providers to notify the State when they are no longer accepting additional Medicaid patients? If yes, please describe the notification process. How does the State consider the (enrolled providers who no longer accept additional Medicaid patients) in its plan to monitor access?

15. What is the current utilization volume of the services that will be affected by this amendment?

16. If rate reductions have been made in two or more years for the same service, please provide information on the following over the course of those years:

    - The changes in the number of participating providers by type and geographic area, who provide services covered under this amendment;
    - A history of the utilization of the services covered under this amendment; and,
    - A history of rate changes for services covered under this amendment for the previous five years.

IMPACT on QUALITY of CARE

17. How did the state determine that the proposed reduction in Medicaid provider payments will not negatively impact quality of care?

18. What types of studies were conducted or what data/information was used by the state to determine that quality of care will not be negatively impacted?

19. How will the state prospectively monitor the impact of the rate reductions on quality of care?

20. Does the state have a plan to implement a remedy should a problem arise with quality of services?

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 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: Stanley Fields
SPA_Waivers_Atlanta_R04@cms.hhs.gov

Sincerely,

Jackie Glaze

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

Cc: Tim Weidler, NIRT
Davida Kimble, ROIV

Stanley Fields, ROIV NIRT
Anna Dubois, ROIV NIRT
Dicky Sanford, ROIV NIRT
Cheryl Wigfall, ROIV
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