DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Singleton/Chavis	3-15-13

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 000282	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR cc: Mr. Keck, COS, Depp, CMS file.	[X] Prepare reply for appropriate signature DATE DUE 5-15-13
	[ ] 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

March 7, 2013

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) 12-024 and 12-025

Dear Mr. Keck:

We have reviewed the proposed amendments to Attachment 4.19-A and 4.19-B of your Medicaid state plan submitted under transmittal numbers 12-024 and 12-025. Effective November 1, 2012, amendment 12-024 proposes to revise the inpatient hospital reimbursement methodology for determining payment rates. Specifically, the following changes are being proposed: (1) update the base year used to calculate the FFY 2012-2013 Disproportionate Share Hospitals (DSH) interim payments; (2) update the inflation rate used to trend the DSH base year cost to the DSH payment period; (3) revise and update the qualification criteria used to determine those DSH hospitals that will be subject to a reduction in their DSH payments; (4) eliminate inpatient hospital retrospective cost settlements and begin reimbursing inpatient hospital services using prospective payment rates; and (5) update swing bed and administrative day rates. Also, effective November 1, 2012, amendment 12-025 proposes to eliminate retrospective cost settlements for most hospitals as well as update the hospital specific outpatient multiplier.

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.

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. Before we can continue processing this amendment, we need additional or clarifying information.

State Plan Amendment SC 12-024

General Comments/Questions

1. Pending SPA SC 12-024 revises material that is currently pending in SPAs SC 11-022 and 12-014. We cannot take action on SC 12-024 until all our concerns for the previous amendments are resolved. In addition, any changes made to SC 11-022 and 12-014 should be included in SC 12-024.

2. Please provide the appropriate budget impacts for federal fiscal year (FFY) 2013 and FFY 2014. Also, provide a pen/ink authorization to include the appropriate dollar amount on the HCFA 179.

3. Please provide the supporting calculation detailing the budget impacts for FFY 2013 and FFY 2014.

4. Please provide the latest inpatient hospital upper payment limit (UPL) demonstration applicable to the FFY 2012/2013 for all classes (state government, non-state government, private). The UPL demonstration should include a comprehensive narrative description of the methodology (step by step) 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, worksheet line and column, claims reports, etc.) in the demonstration. The state should also keep all source documentation on file for review. In addition, please include a detailed narrative description of the methodology for calculating the UPL in the state plan language.

5. The term "cost target" is introduced on page 2, yet not explained until page 16. Please include this term in your listing of definitions.

6. Please include the definition of the term "calibration adjustment" in your listing of definitions.

7. Please define the acronym "MARS."

8. Please define the terms "non-general acute care hospital" and "non-acute care hospitals."

Funding Question Responses

9. The state's response to funding question #2 is confusing. It appears that the state is implying that the state share comes from both certified public expenditures (CPEs) and intergovernmental transfers (IGTs). The state share may come from IGTs **or** CPEs, but not both.
    - Certified Public Expenditures: CPEs are certifications by state or local government entities that have spent funds on items and services that are eligible

for FFP. Unlike IGTs, CPEs do not involve any actual transfer of funds to the Medicaid Agency.

- Intergovernmental Transfers: An actual transfer of funds from one governmental agency to the Medicaid agency.

Please provide documentation, explanations and calculations of how the state share is determined, including specifically defining how costs are being certified for CPEs.

Tribal Consultation

10. Based on your tribal question responses, SC advised that Chief Bill Harris was not in attendance for the Medical Care Advisory Committee (MCAC) meeting on 8/14/2012. SC's response further advises that the agenda and handouts were sent to Chief Harris. Based on the agenda that was provided to CMS, the specifics of SC 12-024 and the handouts which were shared with Chief Harris are not included. Please provide the date/actual documents which were shared with Chief Harris.

Plan Pages

11. Page 2a, Section I.C.d - This section discusses the hospitals that will receive retrospective cost settlements. In this paragraph, new language has been added that reads, "Interim prospective payment rates will be calculated using a cost target...". Please change this language to read, "Interim payment rates will be…" The term "prospective" implies that there will be no cost settlement.

12. Page 2a, Section I.C.d - This section addresses large rural hospitals as defined by Rural/Urban Commuting Area classes. Please define the Rural/Urban Commuting class.

13. Page 10, Section IV. – The first sentence of this section adds the date October 1, 2011. This change cannot be effective prior to the effective date of this SPA (November 1, 2012). Please remove this reference to October 1, 2011.

14. Page 12, Section IV.B.6 – This section states that cost to charge ratios in steps 4 and 5 will be adjusted upward or downward by the audit adjustment factor. Was this a DSH audit or a cost report audit? Please provide detailed computations of how this is applied. Are these changes applied prospectively or to cost settlement? Will these adjustments be made annually going forward? Also include a definition of audit adjustment factor in the definitions section.

15. Pages 15 and 16, Section V.1.b - This section states in part, "The adjusted hospital fiscal year 2011 Medicaid inpatient hospital cost to charge ratio of each hospital, as described in Section IV. (B) (4)(5)(6), is multiplied by each hospital's Medicaid inpatient hospital allowed charges based upon discharges incurred during the period October 1, 2011 through August 31, 2012." This time period was changed from a time period of 12 months to 11 months. Please explain.

16. Page 16, Section V.1.c - This section states that a 1.5% reduction is applied to take into account the difference between the cost report year and the claims data period. Please

explain how this was determined.

17. Page 19, Section VI.A.a - The cost to charge ratio is being updated in this section to .2754. Please include language that this factor will be updated annually.

18. Page 27, Section VII. A.1 - This section discusses the hospital specific DSH limit. The first sentence in this paragraph states, "The interim hospital specific DSH limit for all SC general acute care hospitals that contract with the SC Medicaid Program will be equal to one hundred percent (100%) of the unreimbursed hospital cost for all (i.e., SC and out-of-state) uninsured patients, all Medicaid fee for service patients, all Medicaid managed care patients (including PACE Program participants), SC dual (Medicare/Medicaid) eligible patients, and all Medicaid patients who have inpatient and outpatient hospital services reimbursed by a commercial carrier." This same language is repeated in most part for the border hospitals. This is problematic as this is contrary to the final DSH rule. The final rule and accompanying guidance are clear that individuals with Medicaid or other third party coverage are not considered as uninsured under section 1923(g)(1) of the act. The proposed rule that will revise the definition of uninsured for DSH payments was issued in the Federal Register (FR Doc No: 2012-734, Volume 77, Number 11) on Wednesday, January 18, 2012. However, at this point, the proposed rule has not been finalized. Please remove this language from the amendment.

19. Page 27, Section VII, A, 1. i - This section also mentions unreimbursed cost of services by a commercial carrier twice. Section ii on page 28 discusses unreimbursed costs from commercial carriers three times. As discussed in #18 above, this is not consistent with the definition of uninsured in the final DSH rule.

20. Page 28, Section i – This section states in part, "Out of state border DSH qualifying hospitals and SC non-general acute care DSH qualifying hospitals will only report revenue received from SC residents." Please explain. Is this consistent with the DSH rule?

21. Page 28a, #3 - This section includes a sentence that reads, "The qualification criteria will be developed using as filed hospital fiscal year (HFY) 2010 South Carolina Medicaid fee for service and uninsured individuals' total inpatient and outpatient hospital costs, South Carolina Medicaid Managed Care Organization (MCO) enrollees' total inpatient and outpatient hospital costs, and the Medicare/Medicaid eligible and Medicaid/Commercial inpatient and outpatient hospital costs. These costs, which will be deemed as "DHS Eligible Costs…" We have the same issue as with #18 and #19. In addition, the final DSH rule requires that DSH eligibility be determined based on the final DSH audit of the state plan rate year.

22. Page 28a, #3 – In the language in #11 above, the amendment discusses the qualification criteria. Should this section have stated, "…will be developed using as filed hospital cost reports for fiscal year….?"

Access to Care

Please provide responses to the following questions regarding the state's compliance with Section 1902(a)(30)(A) of the Social Security Act and the regulation 42 CFR 447.204 as it specifically relates to the reductions proposed for inpatient hospital services.

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

24. What types of studies or surveys were conducted or used by the state to ensure 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

25. 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 via this amendment?

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

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

28. 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)?

29. 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 an access problem?

30. What action(s) does the state plan to implement after the rate modification(s) take place to counter any decrease to access if such a decrease is found to prevent sufficient access to care?

31. Are providers required to notify the state when they are no longer accepting Medicaid patients? If yes, please describe the notification process. If not, how does the Agency ensure access to care for those who are turned away by these providers?

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

Note: If any responses to questions #23 – 32 would vary for services under SC 12-025, please explain. These questions will not be repeated below.

State Plan Amendment SC 12-025

HCFA 179

1. Please provide the appropriate budget impacts for FFY 2013 and FFY 2014. Also, provide a pen/ink authorization to include the appropriate dollar amount on the HCFA 179.

2. Please provide the supporting calculation detailing the budget impacts for FFY 2013 and FFY 2014.

Public Notice

3. In the public notice, there is a reference to PT, OT, and Speech therapy rate changes. We want to understand the interaction (if any) of PT, OT, and Speech therapy rate changes and impact on the charge to cost ratio.

Tribal Consultation

4. Based on your tribal question responses, SC advised that Chief Bill Harris was not in attendance for the Medical Care Advisory Committee (MCAC) meeting on 8/14/2012. SC's response further advises that the agenda and handouts were sent to Chief Harris. Based on the agenda that was provided to CMS, the specifics of SC 12-025 and the handouts which were shared with Chief Harris are not included. Please provide the date/actual documents which were shared with Chief Harris.

Funding Question Responses

5. Funding Question #1 - The state's initial response referred to providers retaining 100% of the Medicaid fee schedule rate (base payment) and supplemental payments. Please confirm that providers are receiving and retaining 100% of both the base payments as well as the supplemental payments.

6. Funding Question #2 – Can you confirm that no certified public expenditures are being used in any of the payments associated with this SPA submission?

7. Funding Question #3 – During our last reviews (SC 10-014 and SC 11-007), SC advised that the estimated outpatient hospital settlement was $10,000,000 and that no enhanced payments were being made under the outpatient hospital services program. With the submission of SC 12-025, SC has advised that qualifying rural and burn intensive care

unit hospitals' outpatient hospital cost settlement allowed a payment of $1,000,000. Please clarify whether this is a supplemental payment or an enhanced payment? Also, please explain the discrepancy in the cost settlement and supplemental payment amounts in SC 10-014 and SC 11-007 in comparison to SC 12-025.

8. Please provide the UPL demonstration applicable to the current rate period for all classes (state government, non-state government, private). The UPL demonstrations should include a comprehensive narrative description of the methodology (step by step) 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, worksheet line and column, claims reports, etc.) in the demonstration. The state should also keep all source documentation on file for review. In addition, please include a detailed narrative description of the methodology for calculating the upper payment limit in the state plan language.

State Plan Pages:

9. 4.19B, Page 1 – Per the state plan, payment for services rendered on or after November 1, 2012 for large rural hospitals in the state as defined by rural/urban commuting area classes with total licensed beds of 90 or less will receive retrospective cost settlements that represent 97 percent of allowable SC Medicaid outpatient cost, including base, capital and DME payment.
    - Why are large hospitals with 90 beds or less used as a factor in determining payments applicable to this SPA?
    - How is a "large hospital" defined for purposes of this type of payment? For example, is a hospital with 20 beds considered large?
    - Is the state using 42 CFR 485.620 in its determination of the number of licensed beds for critical access hospitals? If not, how is the state making this determination?
    - For hospitals still eligible for reconciled costs, please clarify how allowed costs are determined.

10. 4.19B, Page 1, Paragraph 2 and Page 1.1, Paragraph 1 - Please confirm the addition of DME costs in allowable SC Medicaid costs and explain how these DME costs will be identified in the cost report.

11. 4.19B, Page 1.1 – Determination of the Statewide Outpatient Hospital Fee Schedule Rates - There is effective date language in the description of the fee schedule and a reference to an agency website with published rates. However, there is no link to a website provided. CMS understands that opposed to posting the SC fee schedules on a statewide website, the state furnishes provider bulletins to alert providers of approved changes to reimbursement after the implementing SPA has been approved. Is this still the manner to which SC shares notification of rates?

12. 4.19B, Page 1.1, Paragraph 1 – The CMS 2552 is a Medicare cost report which contains provider information such as facility characteristics, utilization data, cost and charges by

cost center (in total and for Medicare), Medicare settlement data, and financial statement data. Please remove the reference to it being a Medicare/Medicaid cost report, as it is strictly Medicare. For hospitals that will continue to receive reconciled costs, we need a crosswalk between the old and the new CMS cost reports.

13. 4.19B, Page 1.1, Paragraph 1 – Please define the acronym "MARS."

14. 4.19B, Page 1.1, Paragraph 5 – How was the 95 percent cost target determined?

15. 4.19B, Page 1.1, Paragraph 6 – How was the annual trend factor of 3.5 percent determined?

16. 4.19B, Page 1a, Paragraph 2 – This paragraph introduces language which suggests that a percent reduction is being implemented outside of what was reviewed as part of the July 11, 2011 payment reductions. Please provide additional information about this qualifying burn intensive care unit and why the reduction is necessary? Also, why was it not included in the July 11, 2011 reductions?

17. 4.19B, Page 1a.1, (b) - What line number of worksheet B part 1 will be used to calculate the cost to charge ratio? Which column of worksheet part C will be used to calculate the cost to charge ratio? Please be more specific in the reference to worksheet D, part V when using this information to calculate the cost to charge ratio.

18. 4.19B, Page 1a.1 (d) – Why did SC use the time period of October 1, 2011 through June 30, 2012 as the adjusted hospital fiscal year?

19. 4.19B, Page 1a.1 (d) - The adjusted hospital fiscal year 2011 Medicaid outpatient hospital cost to charge ratio for each hospital is multiplied by each hospital's Medicaid outpatient hospital allowed charges based upon services provided during the period October 1, 2011 through June 30, 2012. Is a claims lag or a claims completion factor used to estimate claims for 3 months to base charges on 12 months of data?

20. 4.19B, Page 1a.1, (e) - According to the state plan, the Medicaid allowable outpatient cost is reduced by one and a half percent (1.5%) to determine the cost target to be used for each eligible hospital to receive a hospital specific outpatient multiplier. The one and a half percent reduction is applied to take into account the difference between the cost report year and the claims data period. Please provide an example of how this policy will be implemented.

21. 4.19B, Page 1a.1 (e) – What is the purpose of the 1.5 percent reduction. How was this percentage determined?

22. 4.19B, Page 1a.1(f) - According to the state plan, the Medicaid cost target for each hospital will be compared to each hospital's corresponding base Medicaid fee for service claims payments (including co-pay and TPL) prior to the application of the hospital specific outpatient multiplier in effect during the payment period outlined in (d) above to

determine the hospital specific outpatient multiplier effective November 1, 2012. To clarify this methodology, please provide an example of how this policy will be implemented.

23. 4.19B, Page 1a.1 (g) – How did SC determine that the hospitals that did not receive a hospital specific outpatient multiplier would receive an assigned multiplier of 93 percent? A crosswalk between the new and old cost reports will be needed for the data used to compute the hospital specific outpatient multiplier

24. 4.19B, Page 1a.3 (B) – The section references objectives; however, the objectives are not listed on the plan page nor are they listed on the following plan page. Please delete this section from the plan. If the state feels this reference should not be deleted, please provide an explanation explaining so.

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: Anna Dubois
SPA_Waivers_Atlanta_R04@cms.hhs.gov

If you have any questions or would like to discuss our comments and questions, please contact Anna Dubois at 850-878-0916.

Sincerely,

Jackie Glaze

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

cc: Maria Sotirelis, CMCS
Stanley Fields, NIRT

Tim Weidler, NIRT
Davida Kimble, ROIV
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