

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO <i>Hess</i>	DATE <i>7-21-11</i>
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DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER <div style="text-align: right; font-size: 1.2em;"><i>100043</i></div>	<input type="checkbox"/> Prepare reply for the Director's signature <div style="text-align: right;">DATE DUE _____</div>
2. DATE SIGNED BY DIRECTOR <hr/> <i>cc: Mr. Heck, Saxon, Jacobs,</i> <i>CMS file, Deps</i>	<input type="checkbox"/> Prepare reply for appropriate signature <div style="text-align: right;">DATE DUE _____</div> <input type="checkbox"/> FOIA <div style="text-align: right;">DATE DUE _____</div> <input checked="" type="checkbox"/> Necessary Action

APPROVALS <small>(Only when prepared for director's signature)</small>	APPROVE	* DISAPPROVE <small>(Note reason for disapproval and return to preparer.)</small>	COMMENT
1.			
2.			
3.			
4.			

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



July 15, 2011

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

Re: South Carolina Title XIX State Plan Amendment, Transmittal #10-005

Dear Mr. Keck:

We have reviewed South Carolina's State Plan Amendment (SPA) 10-005, which was submitted to the Atlanta Regional Office on September 17, 2010. This amendment was submitted to add coverage of targeted case management services for functionally impaired adults. The target group includes Medicaid eligible individuals who must meet the following criteria: individuals who are 18 years of age or older, individuals who lack formal and/or informal resources to address their mental and physical needs, individuals who are unable to perform at least one Activity of Daily Living (ADL) as defined the State NF LOC Criteria, individuals who require targeted case management assistance to obtain needed services.

The 4.19B section of this amendment is being approved to adequately set forth a CMS approved cost methodology in the State Plan. During the review, CMS noted that the actual certification process was not in compliance with CMS policy and therefore an end date of the certification process was agreed upon between CMS and SC effective June 30, 2012. During the interim, SC will work to revise their certification process of their funding to a more comprehensive methodology based on the timing of their payment structure.

Based on the information provided, we would like to inform you that South Carolina SPA 10-005 was approved on July 14, 2011. The effective date is July 15, 2010. The signed CMS-179 and the approved plan pages are enclosed. If you have any questions regarding this amendment, please contact Tandra Hodges at (404) 562-7409.

Sincerely,

A handwritten signature in black ink that reads 'Jackie Glaze'. The signature is written in a cursive, flowing style.

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

Enclosures

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL**

FOR: HEALTH CARE FINANCING ADMINISTRATION

**TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES**

1. TRANSMITTAL NUMBER:
SC 10-005

2. STATE
South Carolina

**3. PROGRAM IDENTIFICATION: TITLE XIX OF THE
SOCIAL SECURITY ACT (MEDICAID)**

4. PROPOSED EFFECTIVE DATE
July 15, 2010

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN

☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN

☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:
Target Group (42 CFR 441.18(8)(i) and 441.18(9))

7. FEDERAL BUDGET IMPACT: : Estimated @ 73.93% for 2011
a. FFY 2011 \$437,500
b. FFY 2012 \$2,100,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Supplement 1 to Attachment 3.1-A, Pages 1m through 1m.5
Attachment 4.19-B, Pages 6e.1 through 6e.4

**9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (If Applicable):**

10. SUBJECT OF AMENDMENT:

TARGETED CASE MANAGEMENT SERVICES FUNCTIONALLY IMPAIRED ADULTS

11. GOVERNOR'S REVIEW (Check One):

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT

☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED

☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

☒ OTHER, AS SPECIFIED:

Ms. Forkner was designated by the Governor
to review and approve all State Plans

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Emma Forkner

14. TITLE: DIRECTOR OF THE PLAN SECTION OR ATTACHMENT
Director

15. DATE SUBMITTED:
September 16, 2010

16. RETURN TO:

South Carolina Department of Health and Human Services
Post Office Box 8206
Columbia, SC 29202-8206

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: 07/14/11

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 07/15/11

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: Jackie Glaze

22. TITLE: Associate Regional Administrator
Division of Medicaid & Children's Health Opns.

23. REMARKS:

- 19.n Targeted case management (TCM) services are provided to Medicaid eligible recipients determined to meet the criteria of functionally impaired adults. These criteria are located in Supplement 1 to Attachment 3.1-A.

The specific targeted case management services to be provided under this section of the state plan are as follows:

- 1) Comprehensive assessment and reassessment,
- 2) Development and revision of care plan,
- 3) Referral activities,
- 4) Monitoring and follow-up.

TCM for this population can be provided by governmental or private providers. In order to develop the Medicaid payment rate, the Medicaid Agency employed the following reimbursement methodology:

1. Personnel costs - We obtained from the South Carolina Department of Social Services (SCDSS), Division of Adult Services, the personnel classifications (from the South Carolina Office of Human Resources (SCOHR) Classifications Manual) of the case managers and their supervisors employed in their Division. Note: This state agency will be a primary provider of these Targeted Case Management services. The SCDSS, Division of Adult Services, also provided the average annual salary for their case managers (Human Services Specialist II) as well as case manager supervisors (Human Service Coordinator I).

These annual averages were used as the base salary costs in the determination of an hourly rate for case management services.

- 1a Clinical Supervision - The determination of the allowable clinical supervision salary add-on is calculated as follows:
 - 1) the annual average salary for a case manager supervisor as obtained from SCDSS is multiplied by the number of case manager supervisors in the SCDSS, Division of Adult Services (i.e. statewide),
 - 2) this product is multiplied by the average percentage of time case manager supervisors spend on clinical supervision activities,
 - 3) the total average salary for all case manager supervisors for clinical activities as calculated above in number 2 of 1a Clinical Supervision is divided by the number of case managers workers in the SCDSS, Division of Adult Services (i.e. statewide). The result obtained represents the annual average clinical supervision salary per case manager.
- 1b. The allocable portion of the annual average salary for the case manager supervisor is added to the average annual salary for the case manager to determine allowable TCM salary costs.

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- 1c. Allowable TCM salary costs are multiplied by the fringe benefit rate for SC state government employees to determine total personnel costs associated with the TCM services.
2. Other direct operating costs. Other costs that can be directly assigned to the TCM service are added. These include:
 - 2a. Travel/transportation costs - The travel expenses associated with visits to the client's home for assessment(s) and monitoring.
 - 2b. Training - Training expenses that directly relate to maintaining certification, qualifications, or licensure for case managers but not to obtain their initial certification.
 - 2c. Supplies - Material and supply costs that are required for direct services to clients.

The overriding principle regarding this cost is that the materials or supplies are required or used by the direct (i.e. hands on) provider of service during the course of treatment or provision of care to the Medicaid recipient.

The following characteristics determine the charging of supplies to a medical service or case management:

- a) commonly provided in the course of care/treatment by the practitioner or case manager without additional charge,
 - b) provided as incidental, but integral to the practitioners' or case managers' services, and
 - c) used by the "hands-on" medical provider or case manager.
3. Indirect costs - Indirect costs (those supporting costs that cannot be directly attributed to the service but rather apportioned over all benefitting programs/services) are recognized by the application of a 10% IDC rate as applied to personnel costs net of fringe benefits. This is in accordance with OMB A-87, Attachment A, section G.
 4. Cost as identified in steps 1 through 3 above are totaled to determine the average annual costs (per case manager) incurred in the provision of targeted case management services to functionally impaired adults.
 5. The maximum number of billing hours that could be anticipated for each case manager was determined. Assuming a billing productivity factor of 60%, the maximum number of billing hours for each case manager was calculated to be 1,170 hours. The calculation is as follows $37.5 \text{ hours per week} \times 52 \text{ weeks} \times 60\% = 1,170 \text{ hours}$.
 6. Next, the average annual cost determined in step 4 above is divided by the maximum number of annual billable hours as determined in (5) above to arrive at an hourly rate for each case manager. The unit measurement for TCM is fifteen (15) minutes. Therefore, the hourly rate is divided by four in order to arrive at the unit billing rate.

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The Medicaid agency will reimburse private providers of Targeted Case Management services to functionally impaired adults using the Medicaid rate methodology described above. Also, the interim rate paid to state owned governmental providers of Targeted Case Management functionally impaired adults will be based upon the Medicaid rate methodology described above. Reimbursement rates for Targeted Case Management services to functionally impaired adults effective July 15, 2010 (and subsequent updates) will be published in Medicaid bulletins distributed to affected providers. State owned governmental providers will be reimbursed at one hundred percent of their allowable Medicaid costs based upon the review and reconciliation of annual cost reports.

Annual Cost Identification and Reconciliation Process for State Owned governmental providers:

Each State Owned governmental provider rendering Targeted Case Management services to functionally impaired adult will be required to submit a CMS approved annual cost report to establish the costs of their services. Allowable costs will be classified as follows:

Direct Costs:

- 1) "Personnel costs - Expenditures from the accounting records of the State Agency for the incurred salaries, payroll taxes, and fringe benefits for the employees providing case management services to functionally impaired adults. For employees who are not assigned to work 100% of their time in services to functionally impaired adults, time sheets will be required to allocate salary, payroll taxes and fringe benefits.

Only those personnel costs for individuals meeting the requirements of TCM Case Manager as described in "Supplement 1 to Attachment 3.1-A", pages 1m.2 and 1m.3 will be considered as allowable expenditures for the cost report and reconciliation.

- 2) Materials and supplies required for the provision of service.

The overriding principle regarding this cost is that the materials or supplies are required or used by the direct (i.e. hands on) provider of service during the course of treatment or provision of care to the Medicaid recipient.

The following characteristics determine the charging of supplies to a medical service or case management:

- a) commonly provided in the course of care/treatment by the practitioner or case manager without additional charge,
- b) provided as incidental, but integral to the practitioners' or case managers' services, and

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- c) used by the "hands-on" medical provider or case manager.
- 3) Training expenses that directly relate to maintaining certification, qualifications, or licensure for case managers but not to obtain their initial certification.
- 4) Travel/transportation costs the travel expenses associated with visits to the client's home for assessment(s) and monitoring.

The State owned governmental providers of this service will report the actual travel/transportation cost incurred by case managers in the provision of case management services as identified through their accounting system. Examples of allowable expenditures include documented mileage paid to case managers for the use of their private vehicles and directly charged and documented expenses of the state providers' fleet vehicles used by case managers.

- 5) Any costs not noted above but directly assignable excluding subcontract arrangements for direct service delivery and costs included in indirect cost determination.

Supervision:

Costs of clinical supervision will be added to the direct costs associated with the case managers. Allowability of supervisory costs is determined based on time and effort reports which will identify and separate administrative activities of the supervisor versus those activities that are clinical in nature (i.e. participating in assessment and care plan meetings, participation in follow-up and re-evaluation activities, review and evaluation of case management documentation). Time and effort reports completed in accordance with HIM-15, Chapter 2300, Section 2313.2 (E) will be used to determine clinical supervision costs.

Indirect Costs:

Allowable indirect costs can be determined by the application of the provider's federally approved indirect cost rate or federally approved cost allocation plan.

Total Allowable Costs of Targeted Case Management services:

The allowable costs for targeted case management services will be the sum of allowable direct costs, clinical supervisory costs as applicable, and indirect costs as determined above.

Service Statistics:

All State Owned governmental providers will be required to accumulate and report service utilization statistics (i.e. units of service) for the total universe of service recipients in keeping with the accumulation of costs by total population of users. The unit measure for this service for all providers, private and governmental, is fifteen (15) minutes.

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Reconciliation of Annual Cost Reports to Interim Payments:

The State owned governmental providers of this service will submit a cost report within 120 days after the close of their fiscal year. Annual cost reports will be desk reviewed for accuracy and compliance with OMB-A87 cost definitions and principles. The result of total allowable costs divided by total units of service (as defined on page 6e.3 in Service Statistics) result in the average allowable unit rate for reconciliation and cost settlement. The average allowable unit rate multiplied by Medicaid units of service (as determined by the SCDHHS MMIS) becomes annual allowable Medicaid reimbursement for the governmental provider. This amount is compared to Medicaid interim payments (including TPL) and any prior adjustments and/or recoupments for these services.

Settlement Procedures:

Should the comparison referred to above (in the Reconciliation of Annual Cost Reports to Interim Payments) identify an overpayment to the provider, SCDHHS will send a letter to the provider requesting repayment within 30 days. Should the comparison identify an underpayment, an adjustment is processed through the MMIS to pay the provider the difference.

This plan expires June 30, 2012.

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**TARGETED CASE MANAGEMENT SERVICES
FUNCTIONALLY IMPAIRED ADULTS**

Target Group (42 Code of Federal Regulations 441.18(8)(i) and 441.18(9)):

[Describe target group and any subgroups. If any of the following differs among the subgroups, submit a separate State plan amendment describing case management services furnished; qualifications of case management providers; or methodology under which case management providers will be paid.]

The target group includes Medicaid Eligible individuals who must meet all the following criteria:

- **Individuals who are 18 years of age or older.**
- **Individuals who lack formal and/or informal resources to address their mental and physical needs.**
- **Individuals who are unable to perform at least one Activity of Daily Living (ADL) as defined in the State NF LOC Criteria.**
- **Individuals who require TCM assistance to obtain needed services.**

X Target group includes individuals transitioning to a community setting. Case-management services will be made available for up to 180 **[insert a number; not to exceed 180]** consecutive days of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions). (State Medicaid Directors Letter (SMDL), July 25, 2000)

Areas of State in which services will be provided (§1915(g)(1) of the Act):

X Entire State

 Only in the following geographic areas: **[Specify areas]**

Comparability of services (§§1902(a)(10)(B) and 1915(g)(1))

X Services are provided in accordance with §1902(a)(10)(B) of the Act.

 Services are not comparable in amount duration and scope (§1915(g)(1)).

Definition of services (42 CFR 440.169): Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Targeted Case Management includes the following assistance:

- ❖ Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. These assessment activities include
 - taking client history;
 - identifying the individual's needs and completing related documentation; and

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- gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual;

[Specify and justify the frequency of assessments.]

An assessment will be performed initially when a referral is received to document the identified need for the TCM services. If a significant change occurs before the 12 month annual assessment, the TCM case manager will need to reassess the individual's needs as significant changes occur to determine the appropriate targeted case management services.

- ❖ Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that
 - specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
 - includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
 - identifies a course of action to respond to the assessed needs of the eligible individual;
- ❖ Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including
 - activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan; and
- ❖ Monitoring and follow-up activities:
 - activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
 - services are being furnished in accordance with the individual's care plan;
 - services in the care plan are adequate; and
 - changes in the needs or status of the individual are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.

[Specify the type of monitoring and justify the frequency of monitoring.]

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Monitoring activities must be conducted monthly through various contacts such as telephone, email, mail, home visit, and/or office visit with the individual, family members, legal representative/guardian, service providers, or other entities to ensure the individual's case management plan (CMP), is adequate to meet the individuals needs.

Face to face quarterly visits will also be required to monitor and address any changes in the individual's needs.

X Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs.
(42 CFR 440.169(e))

Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):
[Specify provider qualifications that are reasonably related to the population being served and the case management services furnished.]

The following provider qualifications for TCM Case Manager must meet at least one of the following:

A. Educational:

1. A master's degree in social work, psychology, counseling, special education, or in a closely related field; or
2. A bachelor's degree in social work, psychology, counseling, special education, or in a closely related field and have at least one (1) year of experience working with the target population; or
3. A bachelor's degree in an unrelated field of study and at least three (3) years of experience working with the target population;

B. Other Criteria: (all required)

1. All case managers who do not have a current professional license must have a minimum of ten (10) hours of annual training relevant to human services and the targeted population. (The annual ten (10) hours of relevant training will be on a pro-rated basis during the first year of employment). Documentation shall include topic, name and title of trainer, training objectives, outline of content, and length of training, location, and outcome of training.
2. Passing of a State approved certification training course.
3. Case Managers must have a current valid driver's license.

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4. **Background checks are required. Case Managers must not have any felony convictions within the last ten (10) years.**
5. **Personnel folders for TCM Case Managers will be maintained at State Office DSS to document that each member of the staff has met the above requirements.**

Freedom of choice (42 CFR 441.18(a)(1):

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.
2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):

_____ Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services: [Identify any limitations to be imposed on the providers and specify how these limitations enable providers to ensure that individuals within the target groups receive needed services.]

Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6):

The State assures the following:

- Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.
- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

Payment (42 CFR 441.18(a)(4)):

Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

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Case Records (42 CFR 441.18(a)(7)):

Providers maintain case records that document for all individuals receiving case management as follows: (i) The name of the individual; (ii) The dates of the case management services; (iii) The name of the provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) Whether the individual has declined services in the care plan; (vi) The need for, and occurrences of, coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

Limitations:

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

[Specify any additional limitations.]