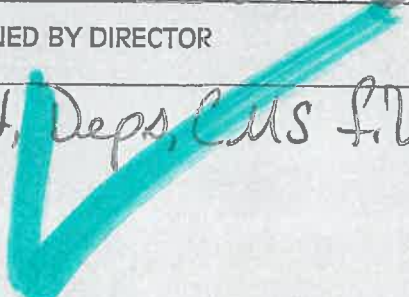


DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO <i>Singleton/Chavis</i>	DATE <i>3-27-15</i>
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DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER <i>000216</i>	<input type="checkbox"/> Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR <i>cc: Host, Deps, CMS file</i> 	<input checked="" type="checkbox"/> Prepare reply for appropriate signature DATE DUE <i>4-27-15</i> <input type="checkbox"/> FOIA DATE DUE _____ <input type="checkbox"/> 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 OPERATIONS

March 11, 2015

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

Attention: Sheila Chavis

RE: Title XIX State Plan Amendment (SPA), SC 14-008 Companion Letter

Dear Mr. Soura:

This letter is being sent as a companion to our approval of South Carolina State Plan Amendment (SPA) 14-008 that was submitted to provide coverage and reimbursement language for the Tuberculosis Program.

The Centers for Medicare & Medicaid Services (CMS) has the following concerns related to our review of SC SPA 14-008 which include Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) sections of Attachment 4-19-B in the state plan. Based on our review, we determined that approval of this section of the state plan is not integral to the approval of the SPA. However, it was noted that RHC and FQHC sections of the state plan do not include the State's process for adjusting rates when there has been a change in scope of service.

In accordance with Medicaid Prospective Payment System (PPS) for FQHC and RHC enacted into law under section 702 of the Benefits Improvement and Protection Act (BIPA) of 2000 requires that the state plan include language that describes the PPS rate adjustment process when there is a change in scope of services.

Section 702 of BIPA 2000 states that the PPS rate must be "adjusted to take into account any increase or decrease in the scope of such services furnished by the center or clinic during the fiscal year". A change in the scope of FQHC/RHC services shall occur if: (1) the center/clinic has added or has dropped any service that meets the definition of FQHC/RHC services as provided in section 1905(a)(2)(B) and (C); and, (2) the service is included as a covered Medicaid service under the Medicaid state plan approved by the Secretary. A change in the 'scope of services' is defined as a change in the type, intensity, duration and/or amount of services. A change in the cost of a service is not considered in and of itself a change in the scope of services. In making such an adjustment, state agencies must add on the cost of new FQHC/RHC services even if these services do not require a face-to-face visit with a FQHC/RHC provider, e.g., laboratory, x-rays, drugs, outreach, case management, transportation, etc.

Mr. Christian L. Soura
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Within 90 days of the date of this letter, the state is required to submit a State plan amendment that resolves the issues, or a corrective action plan to resolve the issues, whichever is most appropriate. During the 90-day period, CMS is available to provide technical assistance to the state. State plans that are not in compliance with the requirement referenced above are grounds for initiating a formal compliance process.

If you have any questions regarding this amendment, please contact Cheryl Wigfall at (803) 252-7299.

Sincerely,

A handwritten signature in cursive script that reads "Jackie Glaze".

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

Enclosures