DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Wells	12-22-08

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER .)00330	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR _____ CC: Ms. Forkner, Deps ✓	[ ] Prepare reply for appropriate signature DATE DUE _____ [ ] FOIA DATE DUE _____ [X] 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 St., Suite. 4T20
Atlanta, Georgia 30303-8909

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

December 18, 2008

Ms. Emma Forkner, Director
South Carolina Department of Health and Human Services
Post Office Box 8206
Columbia, South Carolina 29202-8206

Dear Ms. Forkner:

We have reviewed the proposed State Plan Amendment (SPA) 08-024, which was submitted in order to update the nursing facility room and board rate for residents receiving hospice services, reducing it from 100% to 98% of the facilities' Medicaid room and board rate. In order for CMS to better understand the services and reimbursement methodology proposed by the State in SC 08-024, we are submitting this Request for Additional Information (RAI). We are available to discuss any questions the State may have about the RAI.

Please provide the clarifications requested below:

1. Attachment 4.19-B, Page 6.2, Paragraph 18. Hospice Services: The 179 form indicates that this SPA's purpose is to reduce the nursing facility room and board rate for residents receiving hospice services from 100% to 98% (rather than creating a range) of the facilities' Medicaid room and board rate. However, the methodology on the proposed SPA page 6.2 provides for the hospice agency to reimburse the nursing facility between 95% and 100% of the daily room and board rate. This proposed methodology would appear to allow the payment of different rates to different individual nursing facilities. Therefore, the payment amount for room and board is unclear and cannot be determined from the methodology. Please clarify the reimbursement percentage and replace it with the specific percentage so that the methodology will allow CMS, nursing facilities and other interested parties to determine how payments rates will be established. Also, please indicate whether the proposed change in the reimbursement rate would apply only to nursing facilities, or also to intermediate care facilities for the mentally retarded (ICF/MRs).

2. Attachment 4.19-B, Page 6.2, Paragraph 18. Integrated Personal Care Services: This paragraph indicates that "State developed fee schedule rates are the same for both public and private providers and the fee schedule and any annual / periodic adjustments to the fee schedule are published in Medicaid bulletins." Please revise the paragraph to include an effective date for the current fee schedule, and where it is published. A suggested format for this additional information would be as follows:

> "The agency's fee schedule rate was set as of (date here) and is effective for services provided on or after that date. All rates are published on the agency's website."

3. Attachment 3.1-A, Limitation Supplement, Page 6d and 63:
   a. There is no service entitled, "Integrated Personal Care Services" in Section 1905(a) of the Social Security Act. Please delete all references in the SPA to the term, "integrated."

   b. Please confirm our understanding that this service is limited to adults living in community residential care facilities (a/k/a assisted living facilities). If so, please be advised this may violate the comparability requirements at 42 CFR 440.240 and section 1902(a)(10)(B) of the Social Security Act.

   c. Please include in the SPA the following:
      1. The definition of personal care services, i.e., whether it includes all or one of: assistance with ADLs; IADLs; cueing; or supervision.
      2. Whether PCS are furnished in the beneficiary's home or also in another community location.
      3. The practitioners that will furnish the PCS.
      4. The practitioners' qualifications. The practitioner qualifications should include the level of education/degree required, and any additional general information related to licensing, credentialing, or registration. The practitioner qualifications should also reference any required supervision.

   d. Please explain how practitioners who furnish personal care services are qualified to also furnish medical monitoring and medication administration.

   e. Please explain why the State uses different terminology on page 6e of Attachment 3.1-A, Limitation Supplement with regard to "personal care aides"; on page 2 of Attachment 4.19-B with regard to "personal care I and personal care II services"; and on page 6.2, Attachment 4.19-B of the proposed SPA, with respect to "personal care aide II services."

4. Nurse midwife services reimbursement methodologies are found at Attachment 4.19-B, p. 6.2, Item 17, and also at p. 6h.5, Item 24.g. There should be only one midwife reimbursement methodology present in the State Plan. Consequently, please remove one of these midwife reimbursement sections.

5. CMS 179 Form. The CMS 179 Form indicates an anticipated negative federal budget impact, of ($2,300,000), in FYs 2009 and 2010. Please provide an explanation of how this estimated budget impact was derived.

Standard Funding Questions. The following questions are being asked and should be answered in relation to all payments made to all providers reimbursed pursuant to a methodology described in Attachment 4.19-B of this SPA. For SPAs that provide for changes to payments for clinic or outpatient hospital services or for enhanced or supplemental payments to physician or other practitioners, the questions must be answered for all payments made under the state plan for such service.

1. 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.).

2. 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 through 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 governmental 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).

3. 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.

4. For clinic or outpatient hospital services 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.

5. 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?

If you have any questions related to this request for additional information, please contact Mark Halter on financial issues or Elaine Elmore on programmatic issues. Mr. Halter can be reached at 404-562-7419 and Ms. Elmore can be reached at 404-562-7408. This written request for additional information stops the 90-day clock for the approval process on this SPA, which would have expired on December 29, 2008. Upon CMS approval, FFP will be available for the period beginning with the effective date through the date of actual approval.

Sincerely,

Mary Kaye Justis, RN, MBA
Acting Associate Regional Administrator
Division of Medicaid and Children's Health Operations