DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Wells/Myers	9-24-08

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 000164	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR _____ cc: Ms. Forkner, Deps, Waldrep Cleared 12/3/08, letter attached.	[X] Prepare reply for appropriate signature DATE DUE 12-15-08 [ ] 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
61 Forsyth St., Suite. 4T20
Atlanta, Georgia 30303-8909

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

September 22, 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) SC 08-006 which updates the State Plan to be consistent with federal requirements for targeted case management services for Seriously Emotionally Disturbed Children. This SPA was received in the Atlanta Regional Office on June 30th, 2008 and will reach its 90th day on September 28, 2008.

The Centers for Medicare & Medicaid Services (CMS) requires detail in the descriptions of both services and payment methodology. All services on the same page(s) as the proposed changes covered in the SPA must meet the requirements specified below. Federal regulations at 42 CFR 430.10 describe the State plan as:

> ...a comprehensive written statement submitted by the agency describing the nature and scope of its Medicaid program and giving assurance that it will be administered in conformity with the specific requirements of title XIX, the regulations in this Chapter IV, and other applicable official issuances of the Department. The State plan contains all information necessary for CMS to determine whether the plan can be approved to serve as a basis for Federal financial participation (FFP) in the State program.

Based upon our review of this amendment, the following issues must be addressed prior to approving this amendment:

General Comments:

1) Supplemental Appropriations Act, 2008, Pub. L. 110-252, which was signed into law on June 30, 2008, at section 7001((a)(3), precludes CMS from taking any action prior to April 1, 2009 that would be more restrictive than applied on December 3, 2007 with respect to the provisions of CMS 2237-IFC. CMS has issued a revised SPA outline, which reflects the requirements that continue to remain in effect for this service, as well as, Medicaid statute and regulations. You may wish to use this outline in revising your SPA or for comparing it to the pages submitted to identify any further revisions you would have CMS consider. (A copy is attached for your reference.) We continue to be available to provide technical assistance regarding changes resulting from the moratorium.

2) Please note that consistent with our SPA review policies, we have also reviewed the corresponding payment pages for TCM services at 4.19(b) of the existing plan. Later in this formal request for information we have provided specific questions related to reimbursement. We believe that the State will need to make changes to the 4.19(b) pages, and revise the reimbursement methodology. Consequently, a public notice will be required, consistent with 42 CFR 447.205. The State requested an effective date of April 1, 2008 for this SPA; however, the State has not submitted a public notice pertaining to this SPA. In the absence of a public notice dated March 31, 2008 or earlier, the April 1, 2008 effective date is problematic. Has the State published a public notice? If so, please supply a copy to CMS. If not, when does the State expect to publish the notice and what effective date will the State be seeking for SPA 08-006?

3) Please explain the projected increase in expenditures in relation to this SPA from FY2008 to FY2009.

Coverage Questions

1) As you know, FFP is not allowed for individuals in an IMD (except for services provided to the elderly and children under 21) and for individuals involuntarily living in secure custody of law enforcement, judicial or penal systems. Please address whether the target group may include any of the excluded groups and how the State will assure compliance with this provision as stated in the 2000 Olmstead letter #3 and paragraphs (A) and (B) following paragraph section 1905(a)(28) of the Social Security Act (the Act).

2) In the Limitations section, the State does not assure CMS that the TCM service is not integral to the foster care program, but only assures that the activity is not integral to the administration of the foster care program. Please refer to the revised SPA outline for the language that should be included in this assurance and submit a revised page.

3) How frequently will the case managers be required to update or to reassess the care plan?

4) Please note that the 2001 SMD letter does not prohibit administrative case management for the establishment and coordination of Medicaid services. Does the State intend to provide any TCM activities as an administrative activity? Please describe. If so, the State will need to inform CMS and remove those elements from the State Plan. When a State elects to provide case management as both an administrative and a service expense (either under the targeted case management State plan authority, or as a service under a HCBS waiver), the State must have a policy on file with CMS that clearly delineates the circumstances under which case management is billed as either an administrative or a service expense. This information must be included in the supporting documentation included in the State plan or waiver request. Please provide this policy, if relevant.

5) Under "Access to Services," please change the first sentence to say "Case management services will be provided in a manner consistent with the best interest of recipients and will not be used to restrict an individual's access to other services under the plan; [section 1902 (a)(19).]" This wording comes from the new template enclosed.

6) Under "Access to Services there is a reference to the Single Case Manager: The moratorium restricts CMS from implementing the requirement that case management services be provided by a single case manager as specified in section 441.18(a)(5) of the IFC. The State may remove this requirement from their State Plan.

7) As a result of the Moratorium, the State may remove the language that is included in the last paragraph under "access to services" that FFP is only available to community providers and will not be claimed on behalf of an individual until discharge from the medical institution and enrollment in community services.

8) Case Record: The moratorium restricts CMS from requiring the case record documentation as specified in section 441.18(a)(7) of the IFC. The State may remove this requirement from their State Plan. Does the State intend to require case managers to maintain documentation on each case to support the claims submitted?

9) As a result of the Moratorium, please remove the payment requirement for 15-minute increments as noted in the IFR Preprint/Outline from the State Plan. Please note that CMS will continue to review the 4.19 b pages to ensure that the rates are economic and efficient as required in section 1902(a)(30)(A) of the Act.

10) Under Limitations: please include the following bullet:
- Activities for which third parties are liable to pay. (2001 SMD)

Reimbursement Questions

During the moratorium, existing CMS policies on developing rates that are consistent with economy, efficiency, and quality of care remain in effect. The State should develop a reimbursement methodology for CMS review. We offer the following guidance for your consideration in developing a methodology.

Background

Section 1902(a)(30)(A) of the Social Security Act (the Act) requires that States have methods and procedures to assure that payments are consistent with efficiency, economy, and quality of care. Section 1902(a)(4) of the Act specifies that the State plan must provide for such methods of administration as are found by the Secretary to be necessary for the proper and efficient administration of the plan. Cost-based rates and market-based rates are generally accepted methods of reimbursing TCM providers. Units of service may be as large as weekly units. Monthly rates are more similar to capitated per member per month rates than to fee for service rates and it is CMS's position that they should be subject to the requirements of 42 CFR Part 438.

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Please indicate if the State intends to continue using the existing methodology (SPA 95-011, page 6a, Attachment 4.19-B), that states that the service is

> ... "reimbursed through a fee for service methodology based on the delivery of units of service. A unit of service will be fifteen (15) minutes. The payment rate for a unit of service will be prospectively determined based on the salary of case managers as well as other applicable operating costs. An adjustment based on the actual cost of the delivery of services will be made at the end of each fiscal year. Payment to state agency providers will not exceed the cost of rendering the service."

If so, please provide the details of the methodology for our review. If not, the sections below outline CMS policy regarding rate-setting for cost-based and market-based rates and a series of questions that the State should answer, depending on the method chosen, prior to SPA approval.

Cost-Based Rates

Although CMS cannot limit governmental providers to cost, in general, cost-based rates should be used when a State exclusively reimburses governmental providers for TCM services. The costs included in the rate development must be supported by documentation that represents the costs incurred by governmental entities within the State. The rates are **not reconciled** and may be trended forward or updated from year-to-year. CMS has recognized the following considerations in approved cost-based rates:

a. Salary cost of direct practitioners and supervisors engaged in clinical activities (not supervisors or support staff performing administrative tasks)
b. Fringe benefits such as the employer cost of health insurance, Medicare and Social Security contributions and unemployment insurance
c. Indirect cost – CMS has accepted an indirect rate up to 10 percent but would be willing to consider a higher rate if the State can justify it.
d. Transportation cost.
e. The State may factor in cost associated with time not available for billable activities. CMS has accepted TCM rates that contain some cost for paid State holidays, required training time and vacation in the calculation of non-billable time. The State must provide documentation, such as State statute, to support the amount of non-billable time factored into the TCM rate. Whenever a time study is used to determine time not available for billable TMC activities, it must be approved by CMS. In addition, the State's rate methodology must help to assure that billed time does not exceed cost and/or the time available for TCM providers to render services.

Market-Based Rates

Market-based rates may be paid to private and governmental providers. These rates are developed according to the economic factors that determine the payment amount required to attract willing and qualified private providers. To pay market based rates, a State must currently enroll and actively reimburse private providers. The pool of private providers must be significant so that competitive market forces determine the rates.

Ms. Emma Forkner
September 22, 2008

The following questions should be considered when a State proposes a market-based rate:

1. Does the State propose to use a market-based rate that reflects the reimbursement rate and/or methodology used by commercial payers? If so, please provide a narrative and data that explains how the State set its market-based rate.

2. What is the unit(s) of service for the market-based rate(s)? Note: CMS cannot approve a monthly fee-for-service payment rate that is made regardless of the number of services provided to a Medicaid beneficiary because such rates are not economic and efficient in accordance with Section 1902(a)(30)(A) of the Act. Monthly rates are more similar to capitated per member per month rates than to fee-for-service and it is CMS's position that they should be subject to the contracting requirements of 42 CFR Part 438. If the State wishes to reimburse using a monthly rate, please provide evidence of compliance with these regulations. If the State is unable to comply with the regulations, please modify the reimbursable unit of service.

3. What is the payment rate per unit of service?

4. Does the state look at cost in developing its market-based TCM rate? If so, the costs below are generally accepted by CMS when States set rates for governmental providers and can also be used in developing market-based rates. Please fully explain any costs used in the development of the rate,
   a. Salary cost of direct practitioners and supervisors engaged in clinical activities (not supervisors or support staff performing administrative tasks)
   b. Fringe benefits such as the employer cost of health insurance, Medicare and Social Security contributions and unemployment insurance
   c. Indirect cost – CMS has accepted an indirect rate up to 10 percent but would be willing to consider a higher rate if the State can justify it.
   d. Transportation cost.
   e. The State may factor in cost associated with time not available for billable activities. CMS has accepted TCM rates that contain some cost for paid State holidays, required training time and vacation in the calculation of non-billable time. The State must provide documentation, such as State statute, to support the amount of non-billable time factored into the TCM rate. Whenever a time study is used to determine time not available for billable TMC activities, it must be approved by CMS. In addition, the State's rate methodology must help to assure that billed time does not exceed cost and/or the time available for TCM providers to render services.

Actual Cost

States can also choose to pay providers actual cost. States most often pay actual cost when services are provided by governmental providers and certified public expenditures are used as the source of the non-Federal share. When actual cost is paid, CMS must approve the cost report, line item costs, allocation methodology and, in most instances, time study used to identify Medicaid cost. When actual cost is paid and interim rate may be used, but interim payments must be reconciled on an annual basis to actual cost identified through the CMS-approved methodology.

Ms. Emma Forkner
September 22. 2008

Effective Date/Governmental and Private Provider Language:

Many states are unable to comprehensively describe the fee schedule rate setting methodology for services provided under the Medicaid program or the methodology used to update the rates. To meet the definition of a comprehensive rate methodology, the State must include the "effective" date of the fee schedule. In addition, a State must declare that, unless otherwise noted in the plan, all governmental and private providers are paid the same rates and include the location where rates are published.

State plan reimbursement methodologies are reviewed with respect to the following:

1. Does the state plan specify that governmental and non governmental providers are paid the same, uniform rate unless otherwise noted on the reimbursement pages?
2. Does the State plan contain the effective date of the fee for service rate paid for TCM services?

If the plan does not include this information, CMS requires that the following language be added:

> "Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of case management for persons with chronic mental illness and the fee schedule and any annual/periodic adjustments to the fee schedule are published in (specify where published). 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.

The effective date language ensures that a State submits a State plan when rates are adjusted and issues a public notice in accordance with 42 CFR 447.205.

Effective Date Language is Not Needed:

1. When a state sets rates at a percentage of the Medicare fee schedule and follows the Medicare updates published by CMS.
2. When a state sets rates at a percentage of the Medicare fee schedule for a certain year (e.g., 2005) and trends those rates using an inflation factor identified in the plan.
3. When a state includes a complete, comprehensive, and self contained description of how the fee schedule was determined. The description must have enough information to determine the actual rate.

**Note: Once the State specifies the factor used to update rates, no other adjustments may be made to the fee schedule without a SPA.

Examples

1. If the state plan indicates:

   The fee schedule was established as of (e.g.) 1/1/2002 and is updated by 1% on January 1 of each calendar year.

Action: Have the state confirm that no other updates are made during the year. Also need statement in the plan on whether governmental and private providers are paid the same. No other action is necessary.

2. If the state plan indicates:
   Fee schedule.
   Action: Add the effective date language and the governmental/private language in the plan.

3. If the state plan indicates:
   The payment is based on 90% of the 2004 Medicare rates and is updated by the MCPI.
   Action: Confirm and add when the CPI is used to update the rate. Also need statement in the plan on whether governmental and private providers are paid the same.

We hope this guidance will be helpful to you in developing a reimbursement methodology. CMS remains available for consultation and technical assistance to assist the State in developing a reimbursement methodology that is economic and efficient, should the state require assistance during the process of developing the methodology.

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?

Ms. Emma Forkner
September 22, 2008

If you have any questions related on this request for additional information please contact Elaine Elmore or Rita Nimmons on programmatic issues or Mark Halter on fiscal issues. Ms Elmore can be reached at 404-562-7417, Ms. Nimmons can be reached at 404-562-7415, and Mr. Halter can be reached at 404-562-7419. This written request for additional information stops the 90-day clock for the approval process on this SPA, which would have expired on September 28, 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, R.N, M.B.A.
Acting Associate Regional Administrator
Division of Medicaid and Children's Health Operations

Enclosure

Targeted Case Management
Optional State Plan Amendment Outline

Target Group:

Please describe target group.

For case management services provided to individuals in medical institutions: [Olmstead letter #3]

☐ Target group is comprised of individuals transitioning to a community setting and case-management services will be made available for up to ___ ____ ____ [***insert a number; not to exceed 180***] consecutive days of the covered stay in the medical institution.

Areas of state in which services will be provided:

☐ Entire State

☐ Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide)

Comparability of services:

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

☐ Services are not comparable in amount duration and scope.

Definition of services: [DRA & 2001 SMD]
Case management services are services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Case Management includes the following assistance:

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

- Development of a specific care plan that:
  - Is based on the information collected through the assessment;
  - 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:
  - To help an eligible individual obtain needed services including activities that help link an individual with:
    - Medical, social, educational providers; or
    - Other programs and services capable of providing needed services, such as making referrals to providers for needed services and scheduling appointments for the individual.

- Monitoring and follow-up activities:
  - Activities, and contact, necessary to ensure the care plan is implemented and adequately addressing the individual's needs. These activities, and contact, may be with the individual, his or her family members, providers, other entities or individuals and may be conducted as frequently as necessary; including at least one annual monitoring to assure following conditions are met:
    - Services are being furnished in accordance with the individual's care plan;
    - Services in the care plan are adequate; and
    - If there are changes in the needs or status of the individual, necessary adjustments are made to the care plan and to service arrangements with providers.

Case management may include:

- Contact with non-eligible individuals that are directly related to identifying the needs and supports for helping the eligible individual to access services.

Qualifications of providers:

Please specify provider qualifications that are reasonably related to the population being served and the case management services furnished.

Freedom of choice:

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.

- Eligible recipients will have free choice of the providers of case management services within the specified geographic area identified in this plan.
- Eligible recipients will have free choice of the providers of other medical care under the plan.

Freedom of Choice Exception:

☐ Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services.

Access to Services:
The State assures that:

- Case management services will be provided in a manner consistent with the best interest of recipients and will not be used to restrict an individual's access to other services under the plan; [section 1902 (a)(19)]
- Individuals will not be compelled to receive case management services, condition receipt of case management services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management services; [section 1902 (a)(19)]
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan. [42 CFR 431.10(c)]

Limitations:
Case Management does not include the following:

- Activities not consistent with the definition of case management services under section 6052 of the Deficit Reduction Act; [DRA]The direct delivery of an underlying medical, educational, social, or other service to which an eligible individual has been referred.(2001 SMD)
- Activities integral to the administration of foster care programs; or (2001 SMD) and
- Activities for which third parties are liable to pay. (2001 SMD)

Additional limitations:

Please specify any additional limitations.

Log 164

State of South Carolina
Department of Health and Human Services

Mark Sanford
Governor

Emma Forkner
Director

December 3, 2008

Ms. Mary Kaye Justis, RN, MBA
Acting Associate Regional Administrator
Centers for Medicare & Medicaid Services
Division of Medicaid & Children's Health Operations
61 Forsyth Street, Suite 4T20
Atlanta, Georgia 30303-8909

Re: South Carolina Title XIX State Plan Amendment SC 08-006
Targeted Case Management for Seriously Emotionally Disturbed Children

Dear Ms. Justis:

The South Carolina Department of Health and Human Services would like to withdraw State Plan Amendment SC 08-006 from CMS' review.

If you should have any questions, please contact Felicity Myers, Deputy Director of Medical Services at (803) 898-2501.

Sincerely,

Emma Forkner
Director

EF/mh

Office of the Director
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