

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO <i>Jingleton/Chavis</i>	DATE <i>3-6-15</i>
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DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER <i>000199</i>	<input type="checkbox"/> Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR <i>CC: Kost, Dept, CMS file Cleared 12/14/15, letter attached.</i>	<input checked="" type="checkbox"/> Prepare reply for appropriate signature DATE DUE <i>5-18-15</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

December 16, 2014

Mr. Christian L. Soura, Interim Director
Department of Health and Human Services
P.O. Box 8206
Columbia, South Carolina 29202-8206

RECEIVED

MAR 06 2015

Department of Health & Human Services
OFFICE OF THE DIRECTOR

Attention: Sheila Chavis

RE: State Plan Amendment (SPA) 14-016

Dear Mr. Soura:

We have completed our review of the proposed amendment submitted under transmittal number TN 14-016. This plan amendment proposes to update the outpatient hospital multiplier with an effective date of July 1, 2014. Specifically, the following changes are being proposed: (1) cap the October 1, 2013 hospital specific outpatient multiplier at the 75th percentile for all South Carolina general acute care hospitals, South Carolina (SC) long term acute care hospitals, and the qualifying out of state border general acute care hospitals, and with the exception of Direct Medical Education; (2) qualifying hospital whose hospital specific outpatient multiplier falls below the 10th percentile will be reimbursed at the 10th percentile; (3) hospitals eligible to receive retrospective cost reimbursement and fall under the 10th percentile will be eligible to receive Medicaid outpatient hospital reimbursement in excess of cost excluding any teaching hospital. Before we can continue processing this amendment, we need additional or clarifying information.

General Comments/Questions

1. Pending SPA SC 14-016 revises material that is currently pending in SPA SC 12-025, 13-022, and 14-002. We cannot take action on SC 14-016 until all our concerns for the previous amendment is resolved. In addition, any changes made to SC 12-025, 13-022, and 14-002 should be included in SC 14-016.

Funding Questions Responses

2. Funding Question #1 - South Carolina indicated that cost settlements are supplemental payments. Please be advised that cost settlements are not considered supplemental payments and therefore, the State should refrain from referring to cost settlements as supplemental payments.

3. Funding Question #3 - South Carolina indicated a payment to qualifying rural and burn intensive care unit hospitals outpatient cost settlement of \$2,000,000. Please clarify whether this is a supplemental payment or an enhanced payment.

Attachment 4-19 B Plan Pages

Page 1a 3- Paragraph 5:

4. Please explain why the State is using “discharges occurring”, “inpatient reimbursement”, “inpatient hospital costs”, and “inpatient hospital payments”? We believe this language is not appropriate for outpatient hospital reimbursement.

Access Questions

This amendment implements a supplemental rate reduction, as such; CMS has concerns about the cumulative impact of these rate reductions on access by Medicaid beneficiaries to services and quality of care. Therefore, please provide responses to the following questions regarding the State's compliance with section 1902(a)(30)(A) of the Social Security Act as it specifically relates to the reductions proposed in SPA 14-016. Also, if there is another SPA that would counter balance the impact of this SPA, please provide the SPA number in your responses.

5. How did the State determine that the Medicaid provider payments are sufficient to enlist enough providers to assure access to care and services in Medicaid at least to the extent that care and services are available to the general population in the geographic area?
6. What types of studies were conducted or what data/information was used by the State to determine that quality of care will not be negatively impacted? Please summarize the findings, the date the study was conducted, and the age of the data. Examples of data 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; and
 - Utilization of services by eligibility type over time.
7. 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?
8. Did the State receive any feedback or complaints from the public regarding this rate reduction? If so, how were the complaints addressed and resolved?
9. What types of mechanisms does the State have in place for beneficiaries to raise access issues to the Medicaid agency?

10. 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)?
11. 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?
12. 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?
13. Does the State monitor the number of providers who have closed their practices to additional Medicaid patients (i.e., they no longer accept additional Medicaid patients)? If yes, please provide data on the number of providers by geographic service area and by quarter who have notified the State that they have closed their practices to additional Medicaid patients over the last year or as a result of the pending reductions.
14. Does the State require providers to notify the State when they are no longer accepting additional Medicaid patients to their practice? If yes, please describe the notification process. How does the State consider the (enrolled providers who no longer accept additional Medicaid patients) in its plan to monitor access?
15. What is the current utilization volume of the services that will be affected by this amendment?

Quality of Care Questions

16. How did the State determine that the proposed reduction in Medicaid provider payments will not negatively impact quality of care?
17. What types of studies were conducted or what data/information was used by the State to determine that quality of care will not be negatively impacted?
18. How will the state prospectively monitor the impact of the rate reductions on quality of care?
19. Does the State have a plan to implement a remedy should a problem arise with quality of services?

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, which would have expired on December 29, 2014. A new 90-day clock will not begin until we receive your response to this request.

Mr. Christian L. Soura

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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 federal financial participation (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.

We ask that you respond to this RAI via the Atlanta Regional Office SPA/Waiver e-mail address at SPA_Waivers_Atlanta_R04@cms.hhs.gov. The original signed response should also be sent to the Atlanta Regional Office.

If you have any questions, please contact Cheryl Wigfall at (803) 252-7299 or Stanley Fields at (502) 223-5332.

Sincerely,

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

Log # 199

SOUTH CAROLINA



Nikki Haley GOVERNOR
Christian L. Soura DIRECTOR
P.O. Box 8206 : Columbia, SC 29202
www.scdhhs.gov

Brenda,
This closes out
log # 000199

December 14, 2015

Ms. Jackie L. Glaze
Associate Regional Administrator
Center for Medicare and Medicaid Services
Division of Medicaid & Children's Health
Atlanta Regional Office
61 Forsyth Street, SW - Suite 4T20
Atlanta, Georgia 30303-8909

RE: Request for Additional Information (RAI) on South Carolina Title XIX State Plan Amendment (SPA),
Transmittal # SC 14-016

Dear Ms. Glaze:

This is in response to your Request for Additional Information (RAI) dated December 16, 2014 regarding the above-referenced SPA. Please find below the South Carolina Department of Health and Human Services' (SCDHHS) responses to your questions.

GENERAL Comments/Questions

1. Pending SPA SC 14-016 revises material that is currently pending in SPA SC 12-025, 13-022, and 14-002. We cannot take action on SC 14-016 until all our concerns for the previous amendment is resolved. In addition, any changes made to SC 12-025, 13-022, and 14-002 should be included in SC 14-016.

SCDHHS Response: The SCDHHS has incorporated all changes to SPAs 12-025 and 13-022 into this plan amendment. Please note that SCDHHS withdrew SPA 14-002.

Funding Questions Responses

2. Funding Question #1 – South Carolina indicated that cost settlements are supplemental payments. Please be advised that cost settlements are not considered supplemental payments and therefore, the State should refrain from referring to cost settlements as supplemental payments.

SCDHHS Response: The state has been answering the funding questions based upon previously supplied CMS guidance. The state of SC considers a "cost settlement" payment an additional payment and/or recoupment provided outside of the Medicaid fee for service claim payment and thus a "supplemental payment". On the other hand, any payment made by the state that would be considered an "enhanced payment" would be a payment made outside of the Medicaid fee for service claim payment and be a payment that would exceed the provider's cost (such as a UPL payment) of providing the service. Could CMS please provide its definition of a supplemental payment versus an enhanced payment?

3. Funding Question #3 – South Carolina indicated a payment to qualifying rural and burn intensive care unit hospitals outpatient cost settlement of \$2,000,000. Please clarify whether this is a supplemental payment or an enhanced payment.

SCDHHS Response: Supplemental payment – see response to question #2 above.

Attachment 4-19 B Plan Pages

Page 1a 3- Paragraph 5:

4. Please explain why the State is using “discharges occurring”, “inpatient reimbursement”, “inpatient hospital costs”, and “inpatient hospital payments”? We believe this language is not appropriate for outpatient hospital reimbursement.

SCDHHS Response: The state inadvertently included the inpatient SPA language in the subject plan amendment and has corrected the language accordingly. Therefore please replace the originally submitted page 1a.3 with the enclosed page 1a.3 which has been revised.

Access Questions

This amendment implements a supplemental rate reduction, as such; CMS has concerns about the cumulative impact of these rate reductions on access by Medicaid beneficiaries to services and quality of care. Therefore, please provide responses to the following questions regarding the State’s compliance with section 1902(a)(30)(A) of the Social Security Act as it specifically relates to the reductions proposed in SPA 14-016. Also, if there is another SPA that would counter balance the impact of this SPA, please provide the SPA number in your responses.

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

SCDHHS Response: The SCDHHS has not experienced a decline in the number of contracting hospitals since the subject payment methodology change was implemented. Also please remember that any uncompensated Medicaid FFS outpatient hospital costs are reimbursed under the SC Medicaid DSH program and during FFY 2014 the SCDHHS compensated approximately 53% of uninsured and Medicaid eligible uncompensated inpatient and outpatient hospital costs.

6. What types of studies were conducted or what data/information was used by the State to determine that quality of care will not be negatively impacted? Please summarize the findings, the date the study was conducted, and the age of the data. Examples of data 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; and
 - Utilization of services by eligibility type over time.

SCDHHS Response: Under contract with the Division of Medicaid Policy Research (MPR) at the University of South Carolina, extensive studies are conducted to examine access to primary care and specialty care providers. Understanding geographic patterns of Medicaid enrollment and access to providers first requires that Medicaid recipients and health care providers be spatially located. Using a geographic information system (GIS) and SQL-based automation routines, MPR cleaned and geocoded the addresses of South Carolina Medicaid recipients (residential locations)

in CY 2014. Recipient data are derived from the South Carolina Medicaid Management Information System (SC MMIS). In CY 2014, approximately 99.15% of beneficiaries were geocoded in-state and included in subsequent provider-to-recipient ratio and distance-to-care analyses. The providers were geocoded at the 95% confidence interval for the estimated change in the number of providers per 1,000 recipients. MPR receives monthly beneficiary information, provider files, and claims data. This robust data set allows for the access analysis to be undertaken quarterly to examine MCO network patterns within the context of the recipient health care characteristics. The provider files are supplemented annually with by the provider files from the SC Department of Labor, Licensing, and Regulation (LLR) to determine the number of licensed providers serving Medicaid recipients. See Appendix A – for an updated report using the indicated approach to study access to providers at differing geographical units.

7. 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 by this amendment?

SCDHHS Response: Proposed and final public notices were issued for public comment. Meetings were held with various providers and provider associations to discuss the plan changes and potential impacts. Monthly meetings are held with the SC Hospital Association to discuss any Medicaid related issues including reimbursement.

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

SCDHHS Response: Any comments received from the public were discussed among executive management and reflected via the submission of the final public notice and subject SPA amendment.

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

SCDHHS Response: SC Medicaid beneficiaries have several mechanisms available to them to facilitate raising provider access issues: 1. MCOs are required to provide monthly reports regarding issues of access to network providers and their prompt resolution; 2. Toll-free lines allow for direct communication with the main program staff to indicate access concerns with call back to provider and beneficiaries to address concerns; 3. Beneficiaries have the right of appeal through the formal mechanisms governed by state and federal statutes.

10. 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)?

SCDHHS Response: No - we are not aware of any access issues.

11. 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 access problems?

SCDHHS Response: As indicated in the answer to Q.6, the state undertakes an extensive analysis of access to care as a component of every SPA submission. (See Appendix A –Access Approach with Medicaid Statewide Data) Two major metrics of tracking access geospatially require the examination of change of provider over differing units of geography by type of provider and at ZCTA level. ZCTAs were created by the United States Census Bureau to provide a ZIP Code like unit of aggregation for tabulating summary statistics allowing for capturing information at a smaller unit than the county or zip code levels of analysis. (See Appendix B– Total Primary Care Providers by ZCTA Change CY 2012 to CY 2014).

Additionally, the Medicaid program examines access from the perspective of distance and time to providers at the primary care and specialty care levels. (See Appendix C- Number and Percent of Medicaid Recipients Living Within 5 Miles of the Nearest Primary Care Provider) A problem can be detected as a component of the reduction of providers to beneficiaries and increased distance to providers with the enactment of the SPA using these metrics.

12. 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?

SCDHHS Response: The state would develop a plan should a problem arise and would make the necessary financing and/or programmatic changes to address the situation.

13. Does the State monitor the number of providers who have closed their practices to additional Medicaid patients (i.e., they no longer accept additional Medicaid patients)? If yes, please provide data on the number of providers by geographic service area and by quarter who have notified the State that they have closed their practices to additional Medicaid patients over the last year or as a result of the pending reductions.

SCDHHS Response: As a component of the work with the State, MPR receives LLR data on all licensed physicians. This data is compared to establish the percent of providers currently enrolled in Medicaid or a managed care plan. As an example, as of January 2015, it is estimated the percent of licensed SC physicians who are currently accepting Medicaid is 64%. This type of analysis allows the Medicaid program to determine changes to providers impacted by the SPA for further analysis

14. Does the State require providers to notify the State when they are no longer accepting additional Medicaid patients to their practice? If yes, please describe the notification process. How does the State consider the (enrolled providers who no longer accept additional Medicaid patients (in its plan to monitor access?

SCDHHS Response: The State does not require providers to notify the state when they are no longer accepting additional Medicaid patients to their practice. See response to Question 13 for the mechanism currently in place to track changes.

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

SCDHHS Response: Using CY 2014 Ambulatory care measure, there were 4,737,842 outpatient visits excluding mental health or chemical dependency services. The number of emergency department visits were 722,220. Multiple visits on the same day of service for emergency department visits count as one visit. Similarly, multiple codes with the same practitioner on the same day of service count as one visit. The total number of SC Medicaid fee for service outpatient

hospital claims/visits incurred by the hospitals impacted by this state plan amendment amounted to 79,854 based upon their fiscal year ending 2014 cost reporting period.

Quality of Care Questions

16. How did the state determine that the proposed reduction in Medicaid provider payments will not negatively impact quality of care?

SCDHHS Response: The state Medicaid Agency anticipates that this payment action will not negatively impact the quality of care. *The state proposes to use the Ambulatory Care HEDIS measure as a baseline and to examine changes.* This measure summarizes utilization of ambulatory care for outpatient visits and emergency department visits. For CY2014, the overall rate of outpatient visits was 359.48 visits per 1000 member months for Medicaid beneficiaries and the emergency department rate at 54.80 visits per 1000 member months.

17. What types of studies were conducted or what data/information was used by the state to determine that quality of care will not be negatively impacted?

SCDHHS Response: The state uses data from CMS quality measures to determine that quality of care is not negatively affected by the proposed SPA. HEDIS measures are calculated by type of plan and at different units of geography by providers. See Appendix A for an illustration of geospatial approach. Additionally, CAHPS (Child and Adult) are monitored as a component of quality.

18. How will the state prospectively monitor the impact of the rate reductions on quality of care?

SCDHHS Response: In 2012, the State implemented a quarterly monitoring system with an annual report using a combination of geospatial analysis, HEDIS and CAHPS to aid the monitoring of approved SPA changes. The State proposes to maintain and enhance as appropriate this system with the proposed SPA.

19. Does the state have a plan to implement a remedy should a problem arise with quality of services?

SCDHHS Response: The state will continue to monitor outpatient hospital reimbursement payment and its impact on quality of care issues on an annual basis and will adjust reimbursement accordingly if the need arises via the submission of a state plan amendment.

If additional information is needed or if you have questions, please contact Jeff Saxon at (803) 898-1023 or Sheila Chavis at (803) 898-2707.

Sincerely,



Christian L. Soura
Director