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 J00172	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR _____ cc: Ms. Forkner, Deps, Waldrep ✓	[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. Cleared 2/23/10, letter attached.			
2.			
3.			
4.			

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

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

September 23, 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 08-014 Rehabilitative Services Related to Behavioral Health, which was submitted in order to revise all of the rehabilitative services in Attachment 3.1-A of the SC State Plan. This SPA was received in the Regional Office on June 30, 2008 and will reach the 90th day on September 28, 2008. In order for the Centers for Medicare & Medicaid Services (CMS) to better understand the services proposed by the State in SC 08-005, we are submitting this Request for Additional Information (RAI). We are available to discuss any question the State may have about the RAI.

In order to determine whether the SPA can be approved, we require more information about the services and payment methodology. We review SPAs in the context of the overall State plan for consistency with the requirements of section 1902(a) of the Social Security Act. In reviewing payment methodology, we also independently review the State plan coverage provisions to determine whether the payments are related to allowable Medicaid covered services. Similarly, in reviewing coverage provisions, we independently review the corresponding State plan reimbursement provisions to determine whether the State plan provides for a method of payment for those services that meets statutory and regulatory requirements. In addition, all services or payment methodologies on the same page(s) of the existing State Plan will be reviewed in the same way as the proposed changes covered in the SPA, and these existing services or payments must meet the same requirements as the proposed changes.

General Questions

1) Attachment 3.1-A - On Form 179, the State indicates that only pages 6b and 6c of Attachment 3.1-A will be superseded. However, on the bottom of page 6c in the current State Plan, the sets Rehabilitative Service for Primary Care Enhancement (RSPCE) as a service heading that continues on through most of 6d. Page 6d must be revised because it describes limitations to a program that appears to be eliminated once SC 08-014 is approved.

2) Attachment 4.19-B – In order for this SPA to be approved, the State must submit revised payment methodologies in Attachment 4.19-B for all rehabilitative services. The State has not submitted any 4.19-B pages to date. However, the top of page 6.1 is language concerning Disease Management Organizations. This language also refers to patients receiving disease management services for the disease states of asthma, diabetes, and hypertension through Disease Management Organizations (DMOs). It is CMS'

understanding that the State is only providing disease management for diabetes education, and that the DMOs are a delivery system that the State never implemented, therefore this language should be revised or removed.

3) Please note that consistent with our SPA review policies, we have also reviewed the corresponding payment pages for Rehabilitative 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 08-014?

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

Coverage Questions:

The State submitted a response on September 12, 2008 to our questions sent by e-mail to the State on September 3, 2008. All of our questions focused on our attempts to clarify with the State the issues surrounding Institutions for Mental Disease (IMDs), and the arrangements, i.e., the services, providers, and reimbursement, under which outpatient rehabilitative services are and will be provided to children in South Carolina. In our September 3, 2008 e-mail, we said that,

> "..... if children are living in group homes or child caring institutions of over 16 beds, primarily engaged in providing diagnosis, treatment, or care of children with mental diseases, and the cost of room and board is paid through all-state dollars, that it is acceptable to CMS that the children be transported to community providers for receipt of needed services, including rehab services, and that the community providers can claim to Medicaid and can be paid for those services. This is incorrect. All services furnished to the children residing in IMDs would be excluded from FFP. In other words, services provided and claimed by community providers would not be matched by FFP if the children are residing in IMDs even if the room and board were paid by all-state dollars."

We also note that South Carolina Medicaid states that its "transition was designed in collaboration with CMS to remove any doubt that these facilities are residential in nature and not primarily engaged in the diagnosis, treatment and care of individuals with mental illness." While CMS has provided technical assistance to the State for almost a year in an effort to bring its State Plan into compliance regarding rehabilitative services, CMS has not been in collaboration with the State's requests for transition periods. Ultimately, the State's request for a transition period of July 30, 2009, means that the State is seeking permission to continue to pay for services which would otherwise be impermissible. The CMS cannot make any determination on the State's request for transition periods until all issues relative to this SPA are resolved.

1. The State has indicated in previous answers that it hopes to transition all of its IMDs to "all-state funding" in order "to replace Medicaid per diem treatment funding". We believe that the State has misperceived the requirements for reimbursement. It is insufficient to simply "unbundle" the reimbursement mechanism to allow reimbursement for rehabilitative and other services furnished by providers other than the IMDs or their employees or contractors. CMS wishes to remind the State that we will not reimburse for rehabilitative and other Medicaid services furnished to children residing in IMDs, irrespective of whether those rehabilitative and other Medicaid services are furnished within or outside of the IMDs. Please confirm in the SPA that the State will not be claiming Medicaid reimbursement for any rehabilitative or other Medicaid services furnished to children residing in IMDs, whether or not those services are furnished by or through the IMDs or some other provider.

2. The following questions relate to the State's current system, prior to completing its transition of the IMDs to all-state funding.
Please list all of the providers and provider types that furnish rehabilitative and other Medicaid services to the children residing in the IMDs.
Please list all the services that these providers are furnishing to the children residing in the IMDs.
Are any of the services furnished to children residing in IMDs billed to Medicaid whether or not those services are furnished by or through the IMDs or some other provider?

3 The "DHHS Responses to Questions Related to 08-014 Submitted 9/12/08" to CMS have service descriptions in Attachments A, B and C, entitled, "Children's Behavioral Health Services Provider Manual". These service descriptions do not gibe with the service definitions in the SPA. Please revise the names of the services as well as the service definitions in the Attachments as they should not differ from the SPA definitions.

4. Please explain the relationship, if any, between the different levels of intensity of services, (i.e., the High Management Rehabilitative Services, Moderate Management Rehabilitative Services, Supervised Independent Living and Temporary De-escalation Care), and the residential treatment programs described in the SPA, (i.e., the Level III and Level IV Residential/Inpatient Treatment programs described on Page 6c.5 and 6 of Attachment 3.1-A Limitation Supplement). Please explain how the services listed in Attachments A, B and C are billed and claimed to Medicaid. Please include in the SPA an explanation of the process for determining that an individual may require a higher or lower level of care in the residential treatment facilities.

5. Attachments A, B and C to the State's answers of September 12, 2208 include language to the effect that Medicaid does not reimburse for services or "activities" that are "unstructured" or "non-therapeutic". These are not standards recognized by CMS in the definition of rehabilitative services. CMS will reimburse only for covered rehabilitative services that adhere to the definition of rehabilitative services as outlined in 42 CFR 440.130(d), i.e., medical or remedial services that are recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under State law, for maximum reduction of physical or mental disability and restoration of a recipient to his best possible functional level. Accordingly, please delete references in the SPA and Attachments A, B and C to the States answers of September 12, 2008 to activities that are "structured' or "therapeutic". Also, please delete references in the SPA and the Attachments to habilitation and habilitative services; case

management services; educational, recreational and vocational services; and transportation services.

6. The State indicates under "Rehabilitative Psychosocial Therapy" in Attachment C to the State's answers of September 12, 2008, that this service shall be furnished, at a minimum, once per week. Rehabilitative services must be provided consistent with the beneficiary's assessed needs and rehabilitative services or recovery plan. Please delete references to any arbitrary frequency of service provision and replace them with language that rehabilitative services must be provided at a frequency consistent with the beneficiary's assessed needs and rehabilitative services or recovery plan.

Reimbursement Questions

1. As discussed on July 11, 2008 conference call, CMS requires that the state revise their rates and the corresponding 4.19-B page of the state plan (currently page 6.1 and 6.2) for services provided under this SPA according to the guidance below:

Bundling Overview

CMS has identified two potential statutory violations with bundled rates. The first relates to whether or not the rates are economic and efficient, as required by 1902(a)(30)(A) of the SSA. The second concerns the provisions of 1902(a)(32) of the SSA, which require direct payment to the provider of the service. Many providers receiving per diem and bundled payments for rehabilitative services (such as ACT programs and residential treatment centers) are not recognized under Federal statute as providers eligible to receive a direct payment. Therefore, the only way they can be reimbursed is if the Medicaid payment is being made on behalf of an identifiable Medicaid qualified practitioner in their employ. Since bundled rates are designed to make one payment for a variety of services or practitioners, the payment being made on behalf of each one is not identifiable. A bundled rate does not provide for direct payment to the actual practitioners who would be providing the service and is thus not consistent with the requirements of the statute. With the exception of outpatient hospital and clinic services, providers recognized to provide non-institutional 1905(a) services are individual practitioners.

Types of Bundles

1. Single service bundle (for example, rehab). The state pays a single daily, weekly or monthly rate for a service regardless of the actual number of services provided to a beneficiary, or the actual cost of those services.

2. Multiple service bundle (for example, a bundle consisting of personal care, physical therapy, and nursing services). A daily, weekly or monthly rate reimburses for the package of services regardless of how many of each service the beneficiary receives or the cost.

Typically, payment of the bundle is triggered by receipt of a specific number of services, such as two, in the period.

3. Multiple provider levels within a single service (for example, counseling, where a single rate is set for services that can be provided by a highly skilled/reimbursed professional such as a psychiatrist, or a minimally qualified professional, such as a trained high school graduate). These rates are usually reimbursed in time increments, such as 15 minute units.

State Options
The state has the following options:

a) Unbundle the service by paying individual rates by practitioner level or for individual services.
b) PAIP risk or non-risk contract in accordance with the requirements of 42 CFR 438.
c) Provider contracting – the state would be required to:
   - include language in a contract with the entity receiving the bundled payment that would require that the entity furnish to the state Medicaid agency on an annual basis data on the utilization of Medicaid services by practitioner and cost information by practitioner type and by type of service actually delivered under the bundled rate.
   - base future rate updates on that data.
   - include language in the state plan describing these requirements.
   - provide the contract language to CMS prior to approval of a SPA.

2. For those services which will use option C above, the provider contracting option, CMS requires the specific language below (in quotes) to be placed in the 4.19-B pages for that specific service. We will also require a general description of how the state determined the bundled rate for those services.

"The State Medicaid agency will have a contract with each entity receiving payment under provisions of services as defined in Section 3.1-A that will require that the entity furnish to the Medicaid agency on an annual basis the following:

a. data, by practitioner, on the utilization by Medicaid beneficiaries of the services included in the unit rate and;
b. cost information by practitioner type and by type of service actually delivered within the service unit.

Future rate updates will be based on information obtained from the providers."

3. Effective Date/Governmental and Private Provider Language:

Since the State will use a fee schedule methodology, in order 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.

Please include the following information in the state plan:

"Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of _____ 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.

4. While we appreciate the information on funding and governmental providers received on March 4 and March 14, 2008, we would also like a list of private providers enrolled as a Medicaid provider of these rehabilitative services. Of those private providers, what service was billed most frequently?

5. In the March 14 spreadsheet titled, "State agency IG[D]T Contracts," what is the difference between the contracted amount and the IGT amount as shown. In addition, please provide a breakdown of the most frequently billed service for governmental providers.

Standard Funding Questions

The State has not answered the standard funding questions with respect to rehabilitative services. Please answer the Standard Funding Questions listed below:

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.)

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).

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.

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.

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 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,

Elaine Elmore for

Mary Kaye Justis, RN, M.B.A.
Acting Associate Regional Administrator
Division of Medicaid and Children's Health Operations

Reg-172 Dec 15 Rec'd 2008

State of South Carolina
Department of Health and Human Services

Mark Sanford
Governor

Emma Forkner
Director

February 25, 2010

Ms. Jackie L. Glaze
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 (SPA) SC 08-014 regarding Rehabilitation Services Related to Behavioral Health

Dear Ms. Glaze:

The South Carolina Department of Health and Human Services would like to withdraw State Plan Amendment SC 08-014 regarding Rehabilitation Services Related to Behavioral Health from CMS' review.

If you should have any questions, please contact Felicity Myers, Deputy Director of Medical Services at (803) 898-2803.

Sincerely,

Emma Forkner
Director

EF/mh

Office of the Director
P.O. Box 8206 • Columbia, South Carolina 29202-8206
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CMS
CENTERS for MEDICARE & MEDICAID SERVICES

March 10, 2010

Ms. Emma Forkner, 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 #08-014

Dear Ms. Forkner:

We accept your request, dated February 25, 2010 to withdraw the above State Plan Amendment. We are returning the Form HCFA-179 and the proposed pages.

If you have any questions or need any further assistance, please contact Tandra Hodges at (404) 562-7409 or Philip Bailey at (615) 255-9305.

Sincerely,

Jackie Glaze

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

Enclosures