**DEPARTMENT OF HEALTH AND HUMAN SERVICES**
*OFFICE OF DIRECTOR*

# ACTION REFERRAL

| TO | DATE |
|---|---|
| Wells | 3-16-09 |

| DIRECTOR'S USE ONLY | ACTION REQUESTED |
|---|---|
| 1. LOG NUMBER J0u506 | [ ] Prepare reply for the Director's signature<br>DATE DUE _____ |
| 2. DATE SIGNED BY DIRECTOR _____ | [X] Prepare reply for appropriate signature<br>DATE DUE 6-5-09 |
| cc: Ms. Forkner, Depp<br>Cleared 10/30/09 letter attached. | [ ] FOIA<br>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 Street, S.W., Suite. 4T20
Atlanta, Georgia 30303-8909

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

March 16, 2009



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

Dear Ms. Forkner:

This is an official request for additional information (RAI) about Medicaid State Plan Amendment (SPA) 08-031, Compliance with Medicaid Outpatient Hospital Final Rule – Clarification of Outpatient Facility (Including Outpatient Hospital Clinic) Services Definition. Processing of the plan amendment will cease until such time as the State responds to CMS's concerns as detailed below. Ordinarily, we would require that, in accordance with our guidelines to all State Medicaid Directors dated January 2, 2001, you provide a formal response to this request for additional information by no later than ninety (90) days from the date of this letter. However, on February 17, 2009, the American Recovery and Reinvestment Act of 2009 (ARRA) was signed into law. Section 5003(c) of the ARRA prohibits CMS from taking any action to implement final rule CMS-2213-F, "Clarification of Outpatient Hospital Facility (including Outpatient Hospital Clinic) Services Definition," until June 30, 2009.

CMS is currently reviewing ARRA to determine the appropriate treatment of SPAs reflecting the definitions set forth in CMS-2213-F and is issuing this RAI to stop the 90-day clock. The RAI asks for information related to the clarified definition in CMS-2213-F to better understand the SPA under review. If applicable, we also include questions within this RAI that address issues outside of the scope of CMS-2213-F and that require additional clarification for CMS to approve this SPA. Because we believe that the moratorium is for the purpose of allowing time for Congress and CMS to further review the outpatient rule, we request that States not respond to this RAI until the conclusion of the moratorium.

Also, because this amendment was submitted after January 2, 2001, and is effective on or after January 1, 2001, please be advised that we will 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 actual approval.

We have the following concerns:

**CMS-179**

1) At the time the State submitted this SPA to preserve the December 8, 2008 effective date, the State was still conducting research to fully assess the impact of the outpatient rule, and therefore was unable to complete box 7 of the CMS-179, to indicate the Federal Budget Impact. When you respond to this RAI, please provide the Federal budget impact for Federal fiscal years 2009 and 2010. At that time, please authorize CMS to make a pen and ink change to reflect the submitted budget impact.

2) Please provide back-up documentation for the budget impact. That is, provide information that will enable CMS to determine whether the budget impact has been reasonably estimated.

**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 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?

Under CMS procedures for processing SPAs, we ask that you respond to the request for additional information via e-mail and hard copy. Please e-mail your response to CMS_SPA_Waivers_Atlanta_RO4@cms.hhs.gov

Please submit your hard copy to:

Mary Kaye Justis, RN, M.B.A.
Acting Associate Regional Administrator
CMS, DMCHO
61 Forsyth Street SW, Suite 4T20
Atlanta, Georgia 30303

If you need additional information or clarification concerning our request, please contact Philip Bailey at (615) 255-9305. Thank you for your assistance in obtaining this information.

Sincerely,

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

cc:
Sheri Gaskins (e-mail)
Yvette Moore (e-mail)
Cheryl Wigfall (e-mail)
Mary Holly (e-mail)
Darlene Noonan (e-mail)
Tandra Hodges (e-mail)
Philip Bailey (e-mail)
Faye Hutto (e-mail)

L09#506

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

November 2, 2009



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 #08-031

Dear Ms. Forkner:

We accept your request, dated October 30, 2009 to withdraw the above State Plan Amendment. We are returning the Form HCFA-179 and the proposed page.

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,

Irina Roberts for

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

Enclosures

# State of South Carolina
## Department of Health and Human Services

Mark Sanford
Governor

Emma Forkner
Director

October 30, 2009

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

**RE: Request for Additional Information (RAI) - South Carolina Title XIX State Plan Amendment SC 08-031 – Outpatient Hospital Services**

Dear Ms. Justis:

As a result of rescission of final rule CMS-2213-F, "Clarification of Outpatient Hospital Facility (including Outpatient Hospital Clinic) Services Definition", the South Carolina Department of Health and Human Services wishes to withdraw state plan amendment SC 08-031. Because of this request, we see no reason to respond to the Centers for Medicare and Medicaid Services March 16, 2009 RAI relating to the subject plan amendment.

If you or your staff should have any questions, please contact Mr. Jeff Saxon, Bureau of Reimbursement Methodology and Policy, at (803) 898-1023.

Sincerely,

Emma Forkner
Director

EF/wsh

Office of the Director
P.O. Box 8206 • Columbia, South Carolina 29202-8206
(803) 898-2504 • Fax (803) 255-8235