DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Singleton/Chavis	3-15-13

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 000283	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR _____ cc: Mr. Keck, COS, Deps, CMS file Cleared 12/28/12, letter attached.	[X] Prepare reply for appropriate signature DATE DUE 5-15-13 [ ] 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
Atlanta Regional Office
61 Forsyth Street, Suite 4T20
Atlanta, Georgia 30303

CENTERS FOR MEDICARE & MEDICAID SERVICES

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

March 8, 2013

Mr. Anthony E. Keck
Director
Department of Health and Human Services
P.O. Box 8206
Columbia, South Carolina 29202-8206

RE: South Carolina (SC) Title XIX State Plan Amendment, Transmittal #12-026

Dear Mr. Keck:

South Carolina submitted State Plan Amendment (SPA) 12-026, which was received by the Centers for Medicare & Medicaid Services (CMS) on December 21, 2012. This amendment was submitted to eliminate retrospective cost settlements and establish prospective payment rates effective October 1, 2012, for mental health clinic services, special needs transportation, early intervention service and preventive services for primary care enhancement.

We conducted our review of SC 12-026 according to federal regulations. Based on our previous conversations, before we can continue processing this amendment, we are requesting additional information as follows:

HCFA 179

1. Block 7 – Please provide an explanation/data analysis that supports your conclusions that this amendment will not have an impact on FFP.

Public Notice

2. The public notice filed in The State Media Co, Inc. advised that the Department estimates that a minimal impact on annual Medicaid expenditures would be recognized "since the prospective payment rates will closely 'approximate' current costs which will be established at current defined reimbursement levels of allowable costs or the maximum payment rate cap." What methodology is being used to calculate the current allowable costs and the payment cap? Please provide an illustration of the calculations.

Submission Letter

3. The letter received by CMS on December 18, 2012, advised that the payment rates for Preventive Services for Primary Care Enhancement and Rehabilitative Services for Primary Care Enhancement effective October 1, 2012, will establish a reimbursement rate using 80 percent of the SC Medicare fee schedule for 15 minute unit increments. Does SC use a conversion factor in determining the 80 percent calculation? Please provide an illustration of how this 80 percent rate is calculated for this service.

Tribal Consultation

4. Based on your tribal question responses, SC advised that the submission of SC 12-026 is 'unlikely' to have a direct impact on the tribes. Please provide a more definitive answer as to whether or not the tribes will be impacted.

5. Based on your tribal question responses, SC advised that Chief Bill Harris was not in attendance for the Medical Care Advisory Committee (MCAC) meeting on 5/15/2012. Were the agenda and handouts sent to Chief Harris? If so, please provide the date/actual documents which were shared with Chief Harris.

Funding Questions

6. General - 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.

7. Funding Question # 1 – Please confirm that providers affected by this SPA receive and retain 100 percent of the Medicaid payment.

8. Funding Question #2 – Please confirm the definitions of the following acronyms:
   SCDMH-South Carolina Department of Mental Health
   MUSC-Medical University of South Carolina
   SCDDSN-South Carolina Department of Disabilities and Special Needs
   SCDOE-South Carolina Department of Education
   SCDHEC –South Carolina Department of Education and Control
   SCAHEC- South Carolina Area Health Education Consortium
   SCDJJ-South Carolina Department of Juvenile Justice

9. Funding Question#2 – The response to funding questions #2 indicates that the following services are funded in the following manner:

   - Mental Health Clinic Services - certifying public expenditure (CPE) from the SC Dept. of Mental Health and MUSC - It appears that the basis for the CPE is a fee

schedule rate. Please note that CPEs are used in conjunction with the recognition of cost – a CPE cannot be based on a rate. Please furnish the cost report that will be utilized to certify the cost expended for rendering mental health clinic services and the applicable cost report instructions.

- Early Intervention/Family Training/Sign Language Services – CPE from SCDDSN, intergovernmental transfers (IGT) from SC School for the Deaf and Blind - See comment above regarding CPEs and respond accordingly. In addition, please clarify if the CPE is for early intervention family training and/or sign language.
- Special Needs Transportation – IGT from SC Department of Education - Please provide a copy of the IGT agreement.
- Preventive/Rehabilitative Services for Primary Care – CPE from SCDHEC, IGT from SCAHEC, IGT from SCDHEC and SCDJJ - Please see the above comments in reference to IGT and CPE funding and respond accordingly.

In addition, with regard to each payment listed above, please provide a step-by-step flowchart which starts with the appropriation of funds to either the State Medicaid Agency or a Sister-Agency and ends with the claim of FFP.

This flowchart should include the rendering of a Medicaid service and it should indicate whether funding is under the administrative control of the State Medicaid Agency as well as whether payment is to the provider of record or certification of expenditure is made by the provider of record. If a Sister-Agency is the provider of record, this should be indicated within the flowchart.

10. Funding Question#2 – For the methodologies using IGTs, please confirm that public funds are not federal funds or are federal funds authorized by federal law to be used to match other federal funds.

State Plan Pages

11. 4.19B, Page 0a – The effective date for the mental health clinic reduction of four percent was 7/11/2011. The proposed effective date of completely removing the reduction language is 10/1/2012.

    - Were any reductions to payments implemented to the mental health clinics between 7/11/2011 – 10/1/2012?
    - How is the four percent reduction impacting the new proposed calculated rate (i.e. reduction included in new calculation, reduction totally removed and new increased rate developed)?

12. 4.19B, Page 2, Section 3 – This section revises material that is currently pending in SPA SC 11-020. We cannot take action on SC 12-026 until all our concerns for the previous amendment are resolved. In addition, any changes made to SC 11-020 should be included in SC 12-026. This section references a payment methodology with an end date

of June 30, 2009. Based on this language, SC is no longer authorized to make payments under this methodology. Either delete this reimbursement provision or submit a new payment methodology for this service.

13. 4.19B, Page 2, Section 4b (paragraph 1) – This provision appears to address reimbursement for providers that are not individual practitioners. Please clarify if this provision is specifically applicable to services rendered within clinics and/or other facility providers, and revise your state plan accordingly.

14. 4.19B, Page 2, Section 4b (paragraph 1) – This section advises that practitioners will be paid at a negotiated encounter rate which will not exceed reasonable cost. This language is not comprehensive. To be comprehensive please provide the following information in your SPA:
    - The rate on the plan page, with an explanation on how the encounter rate is determined.
    - What the state considers a payment rate to practitioners that will not exceed reasonable cost.
    - A methodology for determining reasonable cost (i.e., providers may be required to file a cost report for the state to make a determination whether their rate exceeded reasonable cost, or in the absence of a cost report, a methodology on how the state will ensure the rate does not exceed the reasonable cost of providing the services specific to this provision).
    - Information on whether governmental and private providers of this service are paid in the same manner, or if they are paid differently.

15. 4.19B, Page 2, Section 4b (paragraph 3) – This section revises material that is currently pending in SC SPA 11-020. We cannot take action on SC 12-026 until all our concerns for the previous amendment are resolved. In addition, any changes made to SC 11-020 should be included in SC 12-026.
    - Please provide an indication of what types of providers (i.e., clinic, physicians, pharmacists, etc.) are reimbursed for the rendering of vaccines.
    - For the applicable administration fee associated with vaccine administration, please add the following language:

      "Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of *(ex. case management for persons with chronic mental illness)*. The agency's fee schedule rate was set as of *(insert date here)* and is effective for services provided on or after that date. All rates are published *(ex. on the agency's website)*."

16. 4.19B, Page 2, Section 4b (paragraph 4) – This section advises that services rendered by private providers will be paid at 80 percent of the statewide usual and customary fees and services rendered by governmental and non-profit providers are paid at the lesser of 80

percent of statewide usual and customary fees or actual cost. Usual and customary fees generally translate to charges.

In general, CMS does not view payment methodologies that are solely based on charges as economic and efficient, as required by section 1902(a)(30)(A) of the Social Security Act. CMS accepts payment methodologies that reimburse the lesser of charges or a fee schedule, or the lesser of charges or actual cost. However, payment solely based upon charges is problematic.

- How are the usual and customary fees determined and where are these fees identified?
- With regard to the rate for these services, please add the effective date language listed below:

  "Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of *(ex. case management for persons with chronic mental illness)*. The agency's fee schedule rate was set as of *(insert date here)* and is effective for services provided on or after that date. All rates are published *(ex. on the agency's website)*."

- Also, how often is the fee schedule updated?
- Please provide an indication of whether the non-profit providers referenced in this paragraph participate in the funding of their payment by use of CPE or IGT.

17. 4.19B, Page 2, Section 4b (paragraph 5) – *Early Intervention/Family Training Services and Sign Language Services* appears to be a new service that is not currently in the 3.1A section of the state plan. Please include this service in the coverage section. A pen/ink authorization will need to be provided to add the plan page which will include this service.

18. 4.19B, Page 2, Section 4b (paragraph 6) – This paragraph references *state government owned providers*, please revise to read *governmental providers*.

19. 4.19B, Page 2, Section 4b (paragraph 6) thru 4.19B, Page 2a – Please provide a demonstration to illustrate the cost reconciliation process inclusive of cost report instructions and the illustration calculating how the prospective payment rate is derived. Please include all of the supporting documentation as described at the top of attachment 4.19B, page 2.1.

20. 4.19B, Page 2a; Paragraph 3 – Please remove this section on *Home Based Private Duty Nursing Services*. The same paragraph is repeated in paragraph 4 which also has the same title.

21. 4.19B, Page 2a; Paragraph 4 – Please spell out the acronym for DDSN.

22. 4.19B, Page 2a; Paragraph 4 and 5 - Please provide a copy of the actual rate schedule paid for both Private Duty Nursing and Personal Care Services and illustrate how it applies to the interim cost reconciliation noted at 4.19D, Page 30 of this SPA. Also, please explain how the supplemental payments mentioned in that methodology impacts the home based private duty nursing program.

23. Attachment 4.19B, Page 3a.2 thru Page 3a.5 - This section revises material that is currently under review in SC 11-018. We cannot take action on SC 12-026 until all our concerns for the previous amendment are resolved. In addition, any changes made to SC 11-018 should be included in SC 12-026. This section requires a cost reconciliation review and SC needed additional time to compile the necessary supporting documents.

24. Attachment 4.19B, Page 6 - This section revises material that is currently under review in SC 11-020. We cannot take action on SC 12-026 until all our concerns for the previous amendment are resolved. CMS has advised SC that its current methodology limits reimbursement to the "lower of actual allowable Medicaid costs or the maximum rate cap established for each level of service." However, the plan does not provide a cost identification methodology in the state plan. SC was asked to amend its plan page as follows:

    a. The State should revise this page to clearly describe how "actual allowable Medicaid costs" are determined (i.e., direct costs, indirect cost methodology, use of a CMS approved time study, allocation statistic, interim rate methodology, uniform cost report, reconciliation, and settlement process).

    b. The State should also describe how the maximum rate cap will be established or include the effective date of when it was set and the publication source.

25. Attachment 4.19B, Page 6h, Section 24b - This section indicates that payment for emergency ambulance services will be the lesser of charges or the ceiling of the fees established by SCDHHS. Please elaborate on the term "ceiling of the fees". If the charges are $50 and the ceiling of the fee is $40, will the provider receive $40 or some range of an amount that would be capped at $40?

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 March 21, 2013. A new 90-day clock will not begin until we receive your response to this request.

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 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.

If you have any questions or need any further assistance, please contact Cheryl Wigfall at (803) 252-7172 for the financial concerns and Maria Drake at (404) 562-3697 for coverage concerns.

Sincerely,

Jackie Glaze

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

December 28, 2012

Ms. Jackie Glaze
Associate Regional Administrator
Division of Medicaid and Children's Health Operations
Centers for Medicare and Medicaid Services
61 Forsyth Street, Suite 4T20
Atlanta, Georgia 30303

Re: Amendments to South Carolina State Plan for Medical Assistance 11-022

Dear Ms. Glaze:

The South Carolina Department of Health and Human Services (SCDHHS) submitted an amendment to the South Carolina State Plan for Medical Assistance (State Plan) on October 28, 2011 under Transmittal No. (TN) 11-022. This State Plan Amendment (SPA) authorizes Medicaid supplemental payments to hospitals that have entered into a Low Income and Needy Patient Care Collaboration Agreement (Collaboration Agreement) with a state or local governmental entity (GE). The Centers for Medicare and Medicaid Services (CMS) sent a Request for Additional Information (RAI), dated January 18, 2012, in which CMS raised questions regarding TN 11-022 and the Collaboration Agreement, and each of these questions is addressed specifically in the responses below.

As discussed below, TN 11-022 authorizes payments to two categories of hospitals: (1) non-state public hospitals that enter into a Collaboration Agreement with a GE (Affiliated Public Hospitals); and (2) private hospitals that enter into a Collaboration Agreement with a GE (Affiliated Private Hospitals). SCDHHS expects the only non-state public hospitals that will participate in a Collaboration Agreement with a GE as Affiliated Public Hospitals will be the public hospitals owned and operated by that GE. Consequently, for purposes of the documents implementing TN 11-022, SCDHHS considers both the GE and any Affiliated Public Hospitals as a single GE to ensure that the GE does not attempt to circumvent the private donations rules by couching a relationship between an Affiliated Private Hospital and an Affiliated Public Hospital as different from a relationship with the GE itself.

With regard to the Affiliated Private Hospitals receiving Medicaid supplemental payments under TN 11-022, TN 11-022 envisions collaborative endeavors identical to those approved by CMS in Texas, Louisiana and Nevada under which private sector hospitals take on more of the ever increasing burden of providing healthcare for the poor to enable a GE to use more of its public revenue to support the Medicaid program. By working collaboratively to utilize their joint resources more efficiently, GEs and private hospitals will be able to strengthen the healthcare safety-net and ensure the continued availability of healthcare services for the entire low income and needy population. However, SCDHHS recognizes any collaboration between private providers and GEs is susceptible to creating a prohibited provider donation, and SCDHHS is aware of a number of specific concerns recently raised by CMS in other states that filed SPAs

based on the public/private expanded care collaboration model. Therefore, in addition to addressing CMS' specific questions regarding TN 11-022 below, SCDHHS also addresses the concerns CMS expressed in other states and provides further explanation and background as to how we envision TN 11-022 operating, and how the Collaboration Agreement,[1] Conditions of Participation (CoPs),[2] Affiliated Private Hospital Certification[3] and Governmental Entity Certification[4] (collectively the "Certifications") SCDHHS are adopting for this program create adequate limitations to prevent provider donations and the redirection of Medicaid funds. SCDHHS will apply these limitations to the private hospitals through the Affiliated Private Hospital Certification and to the GEs and Affiliated Public Hospitals through the Governmental Entity Certification.

Our expectation is that, by clearly setting out the rules under which GE's may collaborate with private hospitals under TN 11-022, articulating why the limitations contained in those rules are necessary for compliance with federal law, and requiring all of the collaborating entities (GE's, Affiliated Public Hospitals and Affiliated Private Hospitals) to affirmatively certify their current and ongoing compliance with these rules, we will proactively prevent efforts to institute subsequent arrangements that result in provider donations or redirection of Medicaid funds.

BACKGROUND

In accordance with the expanded care collaboration model approved by CMS in Texas, Louisiana, and Nevada, TN 11-022 enables GEs to fund the non-federal share of Medicaid supplemental payments to any private or non-state public hospital that enters into a Collaboration Agreement with a GE. The Collaboration Agreement does not obligate the GE, the Affiliated Public Hospitals or the Affiliated Private Hospitals to provide any services or use any funds for any purpose. Rather, the Collaboration Agreement designates eligibility for Medicaid supplemental payments and sets the framework within which the GE and an Affiliated Hospital may work together to identify services needed by the low income and needy population that the Affiliated Hospital can provide without inadvertently resulting in a provider donation or redirection of Medicaid funds.

In order to maintain continuity of care to low income and needy patients, the Affiliated Private Hospitals will generally enter into contractual arrangements with licensed professionals who previously provided the hands-on care to the same patients.[5] The Affiliated Private Hospitals may not pay the GE or the non-state public hospitals owned or operated by that Governmental Entity to provide care to the poor, as such a payment would constitute a provider donation. Rather, the Affiliated Private Hospitals must deliver any care they choose to provide directly to patients (themselves or through a third party vendor). The decision over whether they will provide a specific type of service, and to what degree they will provide additional charity

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1 Attachment A.
2 Attachment B.
3 Attachment C.
4 Attachment D.
5 Affiliated Private Hospitals may choose to utilize different providers, but from the standpoint of patient continuity of care, we expect they will initially work with the same service providers with whom the GE previously worked. Examples of the types of services we expect the Affiliated Private Hospitals may provide are listed in Attachment E.

services, remains at the sole discretion of the Affiliated Private Hospital choosing to deliver the additional care. Similarly, neither the GE nor the Affiliated Public Hospitals owned or operated by the GE will have an obligation to pay the licensed professionals that deliver the hands-on care, or the Affiliated Private Hospitals contracting with the vendors to provide the care. The implementation of TN 11-022, as described above, uses the same fundamental expanded care collaboration concepts as the supplemental Medicaid programs CMS approved in Texas, Louisiana and Nevada and are currently under review by CMS in Virginia.

RESPONSES TO CMS' CONCERNS EXPRESSED IN OTHER STATES

In addition to responses to your specific questions regarding TN 11-022, following is a list of the concerns raised by CMS in verbal and written correspondence with the Virginia Department of Medical Assistance Services, which is seeking CMS approval for similar SPAs 11-018 and 11-019. SCDHHS seeks to address these questions now to avoid forcing CMS to ask the same questions for TN 11-022.

1. **CMS expressed a concern that "a private hospital that assumes operational costs of a government provider constitutes a transfer of value and a donation. Insomuch as it occurs simultaneously with the development of a supplemental payment program in which the unit of government funds a payment to the private provider seems to create the linkage between the two events."**

CMS previously explained that a provider donation exists when a provider pays for obligations "which were otherwise State only or local government only, obligations often involving health care services to a non-Medicaid individual."[6] The important legal distinction created by CMS' guidance is that while a provider donation exists if a private provider pays for a legal obligation of a governmental entity, a provider donation is not created if a private provider chooses to deliver services the governmental entity has no legal obligation to provide, even if the governmental entity historically provided those services to the poor based on a moral imperative to do so. This distinction between legal and moral obligations in the context of provider donations is a key component underlying TN 11-022. If a public policy decision by a governmental entity creates an ongoing legal obligation for purposes of determining whether a provider donation exists, then whenever a governmental entity limits the parameters of a public welfare program, whether due to policy reasons or budget necessities, in a manner that indirectly shifts some of the responsibility for care onto private providers, a provider donation would arguably result.

Consequently, under TN 11-022, private providers may only expand their charity care programs to encompass services that a GE has no constitutional, statutory, or contractual obligation to provide. The CoPs being adopted in South Carolina explicitly prohibit an Affiliated Private

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6 Cost Limit for Providers Operated by Units of Government and Provisions To Ensure the Integrity of Federal-State Financial Partnership, 72 Fed. Reg. 29748, 29799 (May 29, 2007) (although this regulation was later abrogated for violations of the federal Administrative Procedural Act, we understand that the logic expressed in the federal register still represents CMS' guidance as to the definition of a provider donation) ("2007 Regulations").

Hospital from assuming any legal obligation of a GE (or Affiliated Public Hospital) and, due to CMS' concern that hospitals may not understand that operational costs are the legal obligation of a governmental entity, the CoPs unambiguously prohibit an Affiliated Private Hospital from assuming the operational costs of a collaborating GE or Affiliated Public Hospital.[7]

Moreover, if the GE provides services to indigent patients through a contract with a provider, the CoPs require the GE to terminate that contract if an Affiliated Private Hospital is providing those same services through the same provider.[8] In other words, we recognize that it would be an indirect provider donation for a private entity to pay a professional to provide the same services to patients at the same time a GE maintains a contract to pay the same professional for services to those same patients. However, we also recognize that the past practice of a GE paying for certain services does not create an obligation for the GE to continue to do so in the future. Therefore, as long as the GE extinguishes any legal obligation it had to pay for the services (either to the private hospitals or to the professionals with whom the private hospitals contract), a private sector provider may deliver the same services without creating a provider donation.[9]

We believe these added protections are more than adequate to place Affiliated Private Hospitals, GEs and Affiliated Public Hospitals on notice that an Affiliated Private Hospital's payment for, or assumption of, the legal, operational, or capital costs of a GE or Affiliated Public Hospital constitutes a prohibited provider donation.

2. **CMS expressed a concern that "the affiliation [between Affiliated Private Hospitals and GEs] would then be characterized by the State as a governmental provider. Due to the affiliation between the private provider and the governmental provider, the entity is no longer under the control of the governmental agency, thereby negating governmental status."**

Under TN 11-022, a Collaboration Agreement between a GE and an Affiliated Private Hospital or group of Affiliated Private Hospitals ***does not create a separate entity which is then characterized by the State as a governmental provider***. While the GE and Affiliated Private Hospitals do collaborate, the collaboration does not create a new entity and the GE and Affiliated Public Hospitals remain separate and independent from the Affiliated Private Hospitals at all times. The Affiliated Private Hospitals do not share operational funds, and they do not share

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7 Attachment B, Section I (emphasis added): "A private hospital receiving Medicaid supplemental payments may not be assigned any contractual or statutory obligations of a contributing governmental entity, or of a non-state public hospital owned or operated by that governmental entity, for purposes of the Collaboration Program. ***Furthermore, a private hospital receiving Medicaid supplemental payments may not assume the operational or capital costs of a contributing governmental entity, or of a non-state public hospital owned or operated by that governmental entity. Operational costs include employees, rent, utilities, supplies, and similar overhead expenses of the government entity or public hospital.***"

8 Attachment B, Section I: "However, a private hospital that receives Medicaid supplemental payments may provide indigent care by entering into its own arrangements (contractual or otherwise) with healthcare providers that had previously provided indigent care services to the contributing governmental entity provided the governmental entity has terminated its agreement with the provider."

9 Due to CMS' concerns emanating out of Texas regarding the assignment of contracts from a GE to a provider, South Carolina included the requirement that GEs and Affiliated Public Hospitals may not assign existing contracts to private providers. Attachment D, Section 4(g)(i). Rather, the GE or Affiliated Public Hospital must terminate its existing contract with a service provider, and the private provider must enter into a new agreement with that service provider. Attachment B, Section I.

common ownership, membership, officers, directors, or board members with either the GE or any Affiliated Public Hospital. Thus, under TN 11-022, GEs and Affiliated Public Hospitals remain totally separate entities from the Affiliated Private Hospitals.

The Governmental Entity Certification requires each GE and Affiliated Public Hospital participating in a collaboration to certify that it will not "hold any ownership, membership, or controlling interest in any entity which engages in the provision of low income and needy care on behalf of an Affiliated Private Hospital or group of Affiliated Private Hospitals under the Collaboration Program, nor has the Governmental Entity received any funds from such an entity."[10] The GE and any Affiliated Public Hospitals must also each certify that it "will not have any legal authority to appoint or remove members of the Board of such an entity."[11]

Although the GEs and Affiliated Public Hospitals remain totally separate from the Affiliated Private Hospitals, there are circumstances where the Affiliated Private Hospitals themselves act collectively. For instance, as part of their effort to expand charitable care in the community, the Affiliated Private Hospitals may form a separate corporate entity to deliver that care. This separate entity enables the Affiliated Private Hospitals to obtain any licensure necessary to deliver specific services, more easily facilitate contracts with other providers, share jointly in the liability for the care delivered, obtain malpractice and other liability insurance, centralize the administrative functions necessary to deliver additional care, and benefit from economies of scale. SCDHHS will not characterize any corporate entity formed by the Affiliated Private Hospitals as a GE or Affiliated Public Hospital, and will not allow the separate entity to make intergovernmental transfers (IGTs) to support the Medicaid program (because it is not a unit of government).

The only relationship the GE or Affiliated Public Hospitals may have with the Affiliated Private Hospitals' corporate entity is that the GE or Affiliated Public Hospital may provide facility space, infrastructure resources, and other third party administrative type services, to reduce the cost associated with the Affiliated Private Hospitals expanding their charitable services and to ensure continuity of provider care. Pursuant to the Certifications, the separate entity is prohibited from paying the GE or the Affiliated Public Hospitals for any services they provide as part of the collaboration.[12]

3. **CMS expressed a concern with provisions in other states' Governmental Entity Certifications, which stated that transfers and transactions that: "ii. Constitute fair market value for goods or services rendered or provided by the Governmental Entity to a Participating Hospital" would not be considered cash or in-kind donations for provider donation purposes. CMS believes that "there can be no transfer of value or a return or reduction of payments."**

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10 Attachment D, Section 4(h).
11 *Id.*
12 Attachment C, Section 2(c)(iii): "Neither Hospital ***nor any other entity acting on behalf of an Affiliated Private Hospital*** will make or agree to make cash or in-kind transfers to the Governmental Entity or any non-state public hospital owned or operated by the Governmental Entity" (Emphasis added).

We understand CMS is concerned ancillary transactions between a GE and its Affiliated Private Hospitals are vulnerable to being used as a vehicle for indirect provider donations. The definition of a provider donation includes *in-kind* contributions in addition to pure transfers of funds. Therefore, Affiliated Private Hospitals cannot give *anything* of value to a GE or Affiliated Public Hospital as part of their collaboration. This includes the donation of physical assets for use by the GE or Affiliated Public Hospital, such as buildings, medical equipment, or computers, or the improvement of governmental assets even if those assets are exclusively used for the provision of indigent care or to benefit the people in the community. For the same reasons, the GE must permit Affiliated Private Hospitals to retain any revenue associated with the indigent care they provide (e.g. collections if it is later found that a patient has insurance coverage or is not indigent), and the Affiliated Private Hospital may not assign that revenue to the GE or an Affiliated Public Hospital. More specifically, SCDHHS wants to ensure a private hospital does not enter into an arrangement with a vendor under which the private hospital pays for the costs of the vendor while any revenues generated from the vendor's services inure to the benefit of a governmental entity. Therefore, the CoPs and the Certifications adopted by SCDHHS prohibit the Affiliated Private Hospitals from donating anything of value (either in cash or in the form of an in-kind contribution) to the State or another governmental entity such as the GE or an Affiliated Public Hospital.[13]

As discussed below, there is only one GE that has entered into a Collaboration Agreement currently and neither it nor any of the hospitals its owns, which are its Affiliated Public Hospitals, receive any payments or in-kind transfers from the Affiliated Private Hospitals the GE wishes to support through TN 11-022. However, this does not mean that at some point in the future a GE or Affiliated Public Hospital may not choose to enter into a business relationship with a particular private hospital unrelated to the collaboration (e.g. contracts for actual services rendered, lease payments, contracts for real property, taxes, fees, assessments, or patient transfer agreements under EMTALA). Therefore, South Carolina's CoPs and Certifications include provisions that contemplate the practical reality and necessity of arm's-length fair market value transactions between GEs and private sector hospitals, while placing limitations on any transactions with Affiliated Private Hospitals to ensure they are not used as a guise for an otherwise impermissible provider donation.[14]

South Carolina's CoPs and Certifications ensure compliance on this issue by strictly prohibiting any payment from an Affiliated Private Hospital to a GE or Affiliated Public Hospital for services provided by the GE or Affiliated Public Hospital related to the provision of indigent care under the collaboration.[15] Consequently, if a GE or Affiliated Public Hospital wants to provide any resources such as its staff, facility space, administrative infrastructure for operational management, or billing, collection, or third party administrative services to help private providers care for the poor under the collaboration, the GE or Affiliated Public Hospital may not be paid for these services, even at a fair market value rate. In addition, the CoPs and Certifications limit all other transactions between a GE or Affiliated Public Hospital and

13 Attachment B, Section II; Attachment C, Section 2(c)(iii); Attachment D, Section 4(f).
14 Id.
15 Attachment B, Section II(a); Attachment C, Section 2(c)(iii)(1); Attachment D, Section 4(f)(i).

Affiliated Private Hospitals to ones that are paid at a fair market value and consummated as independent arm's-length transactions in the ordinary course of business between the Affiliated Private Hospitals and the GE or Affiliated Public Hospital.[16]

These provisions mirror the language that was used in the CoPs and Certifications for the Medicaid programs in Texas, Louisiana and Nevada with regard to collaborations between governmental entities and Affiliated Private Hospitals. In essence, we used the same principles CMS utilizes under the Stark Law to ensure hospitals do not make a payment in excess of fair market value as a means to funnel private money to a governmental entity for use as the non-federal share of a Medicaid payment under TN 11-022.[17]

We understand that even though these are the same protections found in supplemental Medicaid programs in other states, CMS no longer feels they are sufficient to prevent ancillary agreements from being used as a vehicle for indirect provider donations. Therefore, in order to ensure that all Affiliated Private Hospitals, Affiliated Public Hospitals and GEs comply with these restrictions, South Carolina added a provision to both the Affiliated Private Hospital Certification and the Governmental Entity Certification that requires all Affiliated Private Hospitals, Affiliated Public Hospitals and GEs to submit a list of all agreements in which there is an exchange of funds or other in-kind transaction between them and/or any related parties.[18] The same provision places a continuing obligation on the Affiliated Private Hospitals, Affiliated Public Hospitals and GEs that enter into a Collaboration Agreement to supplement that list to the extent they enter into any new agreements during the collaboration or change the financial terms. SCDHHS also added language to the Certifications requiring all parties to the Collaboration Agreement to certify that "[a]ll financial transactions between the Governmental Entity and any Affiliated Private Hospital are unrelated to the delivery of low income and needy patient care under their Collaboration Agreement, or the administration of the Collaboration Program."[19] As a final protection, Affiliated Private Hospitals are required to certify that they "will notify SCDHHS of any transfer or transaction that does not comply with this certification and the Conditions of Participation."[20] With these additional protections in place, CMS should be able to sufficiently monitor ancillary transactions to ensure they are not used as a vehicle for indirect provider donations.

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16 Attachment B, Section II(a)(1)-(2); Attachment C, Section 2(c)(iii)(2)-(3); Attachment D, Section 4(f)(ii)-(iii).

17 Section 1877 of the Social Security Act, the "Stark Law," requires that payment from a hospital to a physician that refers to its facility not be in excess of fair market value. This requirement is intended to prevent a hospital from increasing payments to a physician in exchange for referrals to its facility, then characterizing those referral payments as physician compensation. Similarly, the protections put in place related to TN 11-022 are intended to prevent Affiliated Private Hospitals from increasing payments to a GE or Affiliated Public Hospital for the GE to use as the State share for the Medicaid program.

18 Attachment D, Section 2(c); Attachment C, Section 4(b).

19 Attachment D, Section 4(i); Attachment C, Section 2(c)(vi) (similarly stating that "[a]ll financial transactions between the Governmental Entity and any Affiliated Private Hospital, and all financing transactions between any non-state public hospital owned or operated by the Governmental Entity and any Affiliated Private Hospital, are unrelated to the delivery of low income and needy patient care under their Collaboration Agreement, or the administration of the Collaboration Program.").

20 Attachment C, Section 2(c)(iv).

4. **CMS expressed a concern that, "If a vendor bills a collaborative agency for the 'value' of services provided to the governmental agency, what money does the collaborative agency use to pay?"**

There is no "collaborative agency" under TN 11-022. To the extent the Affiliated Private Hospitals form a separate corporate entity to enable them to enter into agreements with caregivers, it will not receive any Medicaid supplemental payments under TN 11-022, as it will not be a licensed hospital eligible for such payments. The separate entity will pay caregivers from its general revenue, which will be comprised of any revenue it generates and from contributions from the Affiliated Private Hospitals' general revenue.

Each Affiliated Private Hospital's general revenue does, by definition, include Medicaid payments for prior Medicaid services the Affiliated Private Hospital rendered. However, Medicaid payments become the sole property of the Affiliated Private Hospital receiving those payments, entitling the hospital to disburse those funds in whatever manner is consistent with its governing policies.[21] Therefore, as the OIG found in its audit of the State of Missouri, providers are free to use funds received in payment for services to Medicaid recipients as they choose, and they can even choose to pool those funds and share them among themselves for whatever reason they deem appropriate, as long as that choice is voluntary.[22]

5. **CMS expressed a concern that "[t]he Intergovernmental Transfer (IGT) is from an escrow account and not a government account." Therefore, "[t]he transfer of funds from the escrow account does not constitute an IGT because the funds are no longer under administrative control of the Governmental Entity."**

Our understanding is that CMS required Texas, Louisiana and Nevada to include language in the Certifications and CoPs strictly limiting the use of escrow accounts, trusts, or other funding mechanisms in such a way as to make it impractical to have one in conjunction with a Collaboration Agreement. Our understanding is that the intent behind prohibiting the use of escrow accounts (or other similar financial mechanisms) is to prevent an accounting for indigent services provided by Affiliated Private Hospitals contemporaneously with the deposit of those funds in a separate financial account used to assure the Affiliated Private Hospitals that an amount similar to their new cost of expanding care is set aside for an IGT.

SCDHHS does not envision the use of escrow accounts, or other funding mechanisms, in connection with Collaboration Agreements, and we understand CMS would prefer the Certifications and CoPs prohibit any use of escrow accounts. Therefore, SCDHHS drafted the CoPs and the Certifications accordingly.[23] The Governmental Entity Certification now states:

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21 *See Alaska Dept. of Health & Soc. Services*, DAB No. 2103, at 24 n.5 (2007), and 72 Fed. Reg. 29748, 29834 (May 29, 2007) (promulgating 447.207(a)). *See also* Office of Inspector General ("OIG"), U.S. Department of Health and Human Services, "Review of Medicaid Disproportionate Share Funds in the State of Missouri," Audit Report A-07-02-0 2097, April 2003.

22 OIG, U.S. Department of Health and Human Services, "Review of Medicaid Disproportionate Share Funds in the State of Missouri," Audit Report A-07-02-0 2097, p. 6, April 2003.

23 Attachment B, Section I(B)(3); Attachment C, Section 2(e); Attachment D, Section 4(d).

"[t]he Governmental Entity must maintain administrative control over all funds prior to submitting them as an IGT, if the Governmental Entity is providing an IGT, and the Governmental Entity will not utilize any escrow, trust, or other funding mechanism as a source for setting aside the non-federal share of Supplemental Payments for the benefit of Affiliated Private Hospitals."[24] Further, the Certification requires that "[a]ny IGTs for purposes of the Collaboration Program must originate from the Governmental Entity's general revenue."[25] We hope this strict prohibition addresses CMS' concerns and we are willing to add any additional language CMS deems appropriate.

6. **CMS expressed a concern that "[a]ssurances that supplemental payments are not contingent upon transfers of value and or contributions are not sufficient to ensure quid pro quo arrangements are not in effect."**

SCDHHS expects that CMS will want to know exactly which parties plan to collaborate under TN 11-022 and exactly what documents those parties will execute to effectuate their collaboration. Currently there is one GE, Spartanburg Regional Health Services District, that has entered into a Collaboration Agreement with three private hospitals (Trident Regional Medical Center, Grand Strand Regional Medical Center, and Colleton Regional Hospital) and three non-state public hospitals owned and operated by the Health Services District (Spartanburg Regional Medical Center, Village Hospital and Spartanburg Hospital for Restorative Care). The Collaboration Agreement is the only document that will be executed directly between the GE (the Health Services District) and the three private hospitals. In addition, we expect the three private hospitals to set up a non-profit corporate entity as a vehicle to deliver care to the poor. That entity intends to enter into a Management Services Agreement with Spartanburg Regional Healthcare System, to enable it to contribute facility space, equipment, software, and staff to the collaborative effort.[26] Finally, all participating GEs, non-state public hospitals and private hospitals will execute the Certifications.[27]

SCDHHS will limit additional participation under TN 11-022 to those hospitals and GEs that submit an executed Collaboration Agreement and Certifications to CMS 30 days prior to the effective date of their Collaboration Agreement and whose collaboration received approval from SCDHHS. This "gatekeeper" mechanism will enable CMS to perform any due diligence CMS feels is needed. We also agree that if CMS feels more time is necessary to conduct additional analysis, CMS may specify a reasonable time frame to SCDHHS, extending the 30-day period, and specifying that CMS' affirmative approval is needed prior to SCDHHS giving its approval of the collaboration. This process provides both SCDHHS and CMS complete transparency with respect to the source of the non-federal share of supplemental payments. SCDHHS does not believe a new SPA will be necessary with the submission of future executed Collaboration Agreements, because the Medicaid supplemental payment authority will already be established through TN 11-022.

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24 Attachment D, Section 4(d).
25 *Id.*
26 Management Services Agreement, attached as Attachment F.
27 Attachments C and D.

7. **CMS expressed a concern over whether "the current service providers (vendors for which the local government contracts will be terminated) [are] reimbursed through 100% local government funds, or are they receiving any state and Federal Medicaid funds for these services?"**

SCDHHS expects the Affiliated Private Hospitals will target services for which vendors are currently paid through 100% State or local government funds. However, the services that a private hospital chooses to provide and the vendors it chooses to hire to deliver the care to patients are at its sole discretion. Even if a GE was receiving State and federal Medicaid funds as a result of paying for the services prior to terminating its legal obligation to pay for them, the GE will not be eligible to continue receiving any State and federal Medicaid funds after the contract with the vendor is terminated because the governmental entity will no longer be paying for those services.

8. **CMS expressed a concern that, "If it is 100% from the local funds, will the local government maintain their level of effort and use the Federal funds to provide additional services through the private facility or will the same level of services be provided but just with a different funding mix?"**

SCDHHS does not know how the GE will use the State or local government money the GE previously spent on the vendor contracts. SCDHHS believes any GE participating in this program will likely use some of the funds it previously spent on vendor contracts to deliver care to people it previously did not have the funds to help, or to reduce planned cuts to care, and use the remainder for the Medicaid program. Nonetheless, there will be no obligation for the GE to use public funds it previously spent on the vendor contracts in any particular manner. In regard to Medicaid funds received by the non-state public hospitals owned by the GE, under federal law, these payments are for uncompensated services the hospitals provided to the Medicaid population defined by 42 U.S.C. 1396r-4(g)(1)(a).

9. **CMS expressed a concern that "if payment under [the SPA] were only subject to the UPL, entry of additional facilities not currently considered would have no impact on aggregate payments. However, since each hospital is also limited to their charges, UPL room could still be available and qualification of additional facilities will increase the aggregate reimbursement. What is the ability of the [GEs] providing the non-Federal share to absorb the potential addition of facilities and reimbursements? Or, can language be added to the [SPA's] participation criteria to limit this occurrence?"**

SCDHHS expects the three private hospitals already planning to participate (listed above) will have combined individual limits in excess of the private hospital aggregate UPL cap. Similarly, SCDHHS expects the three non-state public hospitals already planning to participate (also listed above) will have combined individual limits in excess of the non-state public hospital UPL cap. Therefore, SCDHHS does not believe the addition of new facilities will increase the amount of program funding. If, for some reason, the combined individual caps of the participating hospitals

did not exceed the relevant aggregate cap, SCDHHS will ensure the GE has adequate funds to absorb the potential addition of facilities up to the aggregate cap.

RESPONSES TO CMS' RAIs FOR TN 11-022

Following are SCDHHS' responses to each of CMS specific RAI questions.

1. **Public Process. Please provide information demonstrating that the changes proposed in TN 11-022 comport with public process requirements at section 1902(a)(13)(A) of the Social Security Act and guidance identified in the State Medicaid Director letter issued on December 10, 1997.**

Attached are documents reflecting publication of public notice on August 6, 2011 and September 30, 2011 for TN 11-022, labeled Attachment G.

2. **CMS Form 179 - Box 7. Please provide your detailed analysis of the estimated federal fiscal impact for the applicable Federal Fiscal Years.**

The State has modified the estimated federal fiscal impact for the applicable Federal Fiscal Years based on its calculation of the aggregate UPL cap under 42 CFR 447.272 and CMS' determination of the Federal Medical Assistance Percentage ("FMAP") for South Carolina for Federal Fiscal Year 2013. Attached is the State's analysis of the estimated federal fiscal impact for the applicable Federal Fiscal Years for TN 11-022, labeled Attachment H.

3. **Please describe the source of the state matching funds for this agreement. If the funds will be from intergovernmental transfers from local governments please provide a copy of the agreements that each local government will enter into with the state or documents that bind them to participate and provide the state matching funds.**

The source of the State matching funds under the SPA may eventually come from both State general revenue appropriated by the South Carolina Legislature to South Carolina DHHS and from voluntary IGTs from subdivisions of the State such as units of local government. Currently, the only governmental entity that intends to participate is Spartanburg Regional Health Services District. There will be no agreement between Spartanburg Regional Health Services District or another unit of local government and the State related to this SPA, and no other document that will bind Spartanburg Regional Health Services District or any other unit of local government to participate and provide the State matching funds. Each unit of local government that wants to participate in the program by providing an IGT will be required to execute the Collaboration Agreement with a hospital or hospitals, but this Agreement is not with the State and does not bind the unit of local government to provide an IGT. Attached is a copy of the form Collaboration Agreement the State will require each participating unit of local government to use (Attachment A). As discussed above, SCDHHS will also require each unit of local government to sign a certification form certifying the unit of local government's compliance with Conditions of Participation for the program adopted by SCDHHS, but this also does not represent an agreement with the State or bind the unit of local government to provide an

IGT. Attached is a copy of the certification form SCDHHS will require from each unit of local government (Attachment D), as well as a copy of the Conditions of Participation (Attachment B).

4. **Upper Payment Limit (UPL) Demonstration - Regulations at 42 CFR 447.272 require that payments in the aggregate will not exceed a reasonable estimate of what Medicare would pay for similar services. Please provide the UPL demonstration applicable to the current rate year for all classes (state government, non-state government, private) of hospitals that are affected by this amendment. The UPL demonstrations should include a comprehensive, step by step, narrative description of the methodology used to determine the UPL. The demonstration should also include a spreadsheet with provider specific information that starts with the source data and identifies the numerical result of each step of the UPL calculation. All source data should be clearly referenced (i.e., cost report year, W/S line and column, claims reports, source of inflation factors, etc.) in the demonstration. The State should also keep all source documentation on file for review.**

Attached are the inpatient aggregate UPL demonstrations for private and non-state public hospitals, labeled Attachment I. A narrative description of the methodology used to determine the UPL for each hospital group is provided in response to Question 11 below.

5. **Page 25, Section II, 10, J. This section has been amended to include language that acute care hospitals that qualify for DSH shall have the supplemental payments provided for in this amendment exempt from the retrospective hospital cost settlement. As written the amendment cannot be approved. The final disproportionate share hospital regulation at 42CFR 447.299(c)(9) requires that all Medicaid payments received by a provider must be offset in determining the uncompensated care cost for services provided to Medicaid and uninsured patients. Please remove this language from the amendment.**

Under the current Medicaid State Plan, the State makes interim Medicaid payments to general acute care hospitals that are then retrospectively cost-settled to a percentage of their Medicaid cost, currently between 90.89% and 97%. The State also makes Medicaid DSH payments to hospitals up to 100% of their unfunded uninsured costs. Under the federal Medicaid DSH limit established in 42 U.S.C. 1396r-4(g)(1)(a) and implemented by 42 CFR 447.299(c)(9), hospitals are entitled to receive payments up to 100% of their Medicaid and uninsured costs. Therefore, the State is adopting TN 11-022 to authorize Medicaid supplemental payments to hospitals based on the difference between this ceiling (100% of Medicaid and uninsured costs) and their current payments (interim Medicaid payments, Medicaid cost settlements, Medicaid DSH payments, and uninsured payments).

This is implemented by Section V(O)(2)(b) of the SPA, which requires that no hospital participating in the Medicaid DSH program will receive Medicaid payments (including payments under TN 11-022) that exceed the federal Medicaid DSH limit established in 42 U.S.C. 1396r-4(g)(1)(a) and implemented by 42 CFR 447.299(c)(9).

If the State makes the change CMS requested in this Question #5, the Medicaid supplemental payments authorized under TN 11-022 would be offset against each hospital's cost settlement under Section II(10)(J). Therefore, the supplemental payments under TN 11-022 would not result in any additional expenditure and would instead only replace existing cost settlement payments (not the State's intent).

The State requests that CMS revisit its requested change in light of this information.

The State also requests additional changes to Section II(10)(J) at Page 25 of the SPA to ensure the accurate application of the concept discussed above and to address the fact that, since the State drafted TN 11-022, additional language has been added to Section II(10)(J) of Page 25 of the State Plan. Specifically, the State wishes to remove the language struck through below from the SPA and add the phrase underlined below to the SPA:

> "All SC general acute care hospitals contracting with the SC Medicaid Program that qualify for the SC Medicaid DSH Program will receive retrospective cost settlements that, when added to fee for service and non-fee for service (i.e. adjustment) payments, ~~(other than payments authorized in Section VI(O))~~, will represent one hundred percent (100%) of each hospital's allowable SC Medicaid inpatient costs. However, effective for discharges occurring on or after July 11, 2011, all SC general acute care hospitals except those designated as SC critical access hospitals, SC isolated rural and small rural hospitals as defined by Rural/Urban Commuting Area classes, certain SC large rural hospitals as defined by Rural/Urban Commuting Area classes and located in a Health Professional Shortage Area (HPSA) for primary care for total population, and qualifying burn intensive care unit hospitals which contract with the SC Medicaid Program will receive retrospective cost settlements, that, when added to fee for service and non-fee for service payments (i.e. interim estimated cost settlements paid via gross adjustments) other than payments authorized in Section VI(O), will represent ninety-three percent (93%) of each hospital's allowable SC Medicaid inpatient costs which includes both base costs as well as all capital related costs except for the capital associated with Direct Medical Education (DME)."

Attached as Attachment J is an updated SPA with this language, which the State believes should assuage any CMS concerns that hospitals will be paid greater than 100% of cost.

6. **Page 26b, Section V.O.1. Qualifying Criteria. This section provides the criteria to determine the providers that qualify for the supplemental payments. To qualify the hospital must be affiliated with a state or unit of local government through a Low Income and Needy Patient Care Collaboration Agreement and be a hospital operated by a private entity. To assist with our review please provide a list by name of each provider and state or unit of local government that will participate in the Collaboration Agreements, a copy of the agreement and the Hospital Certification of Participation Agreement.**

Attachment A is an example Collaboration Agreement. Attachments C and D are examples of the certifications SCDHHS will require from each participating state or unit of local government, participating non-state public hospital and participating private hospital. At this time, prior to CMS' approval of these documents or the SPA, the only providers or state or units of local government that have executed the Collaboration Agreement are one unit of local government (Spartanburg Regional Health Services District) and six hospitals that intend to participate in the public/private collaborative: (1) Trident Regional Medical Center (privately owned and operated, included on line 26 of the table labeled "South Carolina 2012 Aggregate UPL – Private Hospitals" in the Aggregate UPL Demonstration at Attachment I); (2) Grand Strand Regional Medical Center (privately owned and operated, included on line 29 of the table labeled "South Carolina 2012 Aggregate UPL – Private Hospitals" in the Aggregate UPL Demonstration at Attachment I); (3) Colleton Regional Hospital (privately owned and operated, included on line 45 of the table labeled "South Carolina 2012 Aggregate UPL – Private Hospitals" in the Aggregate UPL Demonstration at Attachment I); (4) Spartanburg Regional Medical Center (non-state public, included on line 9 of the table labeled "South Carolina 2012 Aggregate UPL – Non-State Public Hospitals" in the Aggregate UPL Demonstration at Attachment I); (5) Village Hospital (non-state public, included on line 22 of the table labeled "South Carolina 2012 Aggregate UPL – Non-State Public Hospitals" in the Aggregate UPL Demonstration at Attachment I); and (6) Spartanburg Hospital for Restorative Care (non-state public, included on line 54 of the table labeled "South Carolina 2012 Aggregate UPL – Non-State Public Hospitals" in the Aggregate UPL Demonstration at Attachment I).

Also, the State erred in its initial submission by limiting the hospitals that could collaborate with a governmental entity to only privately-operated hospitals when the State's intent was to include both privately-operated hospitals and hospitals that are structured and operated as a regional health services district. The State has revised the SPA accordingly. The updated SPA language is contained in Attachment J.

In addition, please provide a copy of the State Statute or Regulations that define private hospitals and state or units of local government.

The State does not have State statutes or regulations that define the term "private hospitals." The State is using the term to refer to hospitals that meet the federal definition of "privately owned or operated" hospitals in 42 C.F.R. § 447.272, which places hospitals into three categories for purposes of determining Medicare-based aggregate UPL caps on Medicaid payments. All of the hospitals in the State that meet the definition of "private hospitals," as the term is used in TN 11-022, are listed in the South Carolina Aggregate UPL Demonstration, contained in Attachment I, on the table labeled "South Carolina 2012 Aggregate UPL – Private Hospitals." The same federal regulation distinguishes non-state public hospitals, which are described as "all government facilities that are neither owned nor operated by the State." Each hospital in the State meeting that definition is included in Attachment I in the table labeled "South Carolina 2012 Aggregate UPL – Non-State Public Hospitals." Finally, 42 C.F.R. § 447.272 distinguishes state government owned or operated facilities, describing those hospitals as "all facilities that are either owned or operated by the State." Those hospitals are included in an aggregate UPL demonstration submitted to CMS as part of a previous SPA, and are not addressed in TN 11-022.

Currently, the only six hospitals that will receive Medicaid supplemental payments under TN 11-022 are listed above. The State will notify CMS before permitting any other hospitals to receive payments under TN 11-022, and will notify CMS regarding the category (privately owned and operated or non-state public) for that hospital. State hospitals are not eligible to receive payments under TN 11-022.

The State also does not have State statutes or regulations that define the term "state or units of local government." The State is using this term to refer to entities that are eligible to participate in "the financing of the non-Federal portion of medical assistance expenditures" under 42 C.F.R. 433.50. Section 433.50(a) "interprets and implements Section 1902(a)(2) of the Act which requires States to share in the cost of medical assistance expenditures and permit both State and local governments to participate in the financing of the non-Federal portion of medical assistance expenditures." Spartanburg Regional Health Services District is the only State or unit of local government that currently intends to participate under TN 11-022 by making IGTs to SCDHHS, the State Medicaid agency. Spartanburg Regional Health Services District is a regional healthcare district, which is a unit of local government structured and operated under South Carolina statutes 44-7-2150 through 44-7-2157. The State will notify CMS before permitting any other entity to provide the non-federal portion of payments under TN 11-022.

Also, please provide the criteria used to determine Low Income and Needy patients and how they are different than the criteria used to determine Medicaid and Uninsured patient's eligibility.

The Collaboration Agreement does not use the term "Low Income and Needy patients" as a defined term to reference a population with specific eligibility criteria. The Collaboration Agreement memorializes collaboration between a hospital or hospitals and a unit of state or local government to improve access to health care for persons they choose to serve. Each collaborative will need to determine the healthcare needs of the area it chooses to serve and which patients represent the low income and needy patients they will serve in that area. The State is not prescribing which patients each collaborative determines need services, as privately-provided charity services are outside the purview of the Medicaid program.

7. **Page 26b, Section V.O.1. Reimbursement Methodology. This section describes the method to be utilized to calculate the Medicare upper payment limit (UPL) as the lesser of the difference between the hospital's Medicaid inpatient billed charges and the Medicaid payments including any Medicaid inpatient cost settlements or the difference between the hospital's specific DSH limit and the hospital's DSH payments during the State Plan Rate Year. Neither one of these methods are acceptable for the determination of what Medicare would pay for these services provided to Medicaid recipients.**

42 CFR 447.252 provides for the determination of the Medicare UPL based on a reasonable estimate of what Medicare would pay for these services. The methods acceptable for determining this estimate are (i) cost based on Medicare cost principles, or (ii) based on the Medicare prospective payment system, such as, per discharge payments adjusted for difference in acuity or

diagnosis related groups. Please submit an acceptable methodology for estimating the UPL.

The State believes there may be some confusion regarding the intent of the language in Section V(O)(2) and will clarify the language of the SPA accordingly. The State believes the Medicare UPL must be calculated based on the principles articulated in 42 CFR 447.272, which limits Medicaid payments to three groups of providers in the aggregate (state, non-state governmental and private).

However, Section V(O)(2) does not address the aggregate Medicare UPL. Rather, Section V(O)(2) ensures the SPA complies with other, provider-specific caps on Medicaid inpatient reimbursement reflected in federal law. These provider-specific federal caps on Medicaid inpatient reimbursement are located in 42 U.S.C. 1396r-4(g)(1)(a) and 42 C.F.R. 447.271. The State will revise Section V(O)(2) of the SPA to clarify that these are the laws addressed in this section, and that these caps apply on a provider-specific basis, by adding the following underlined language:

> "Reimbursement Methodology. Each qualifying hospital shall receive quarterly supplemental enhanced payments for the inpatient services rendered during the quarter. In addition to the limitations resulting from the application of the upper payment limit for hospitals reflected in 42 C.F.R. 447.272(a)-(b), annual supplemental enhanced payments to each qualifying hospital in any Medicaid State Plan rate year shall be limited to the lesser of:"

This change is reflected in the attached SPA language, labeled Attachment J. This clarification may also help CMS better understand the State's response to Question 5. Also, the State wishes to clarify that, although Section V(O)(2) is not intended to address the Medicare UPL, the State does agree that payments under TN 11-022 are limited by the Medicare UPL. The Medicare UPL is applied to payments under TN 11-022 in the first paragraph of Section V(O), which states: "Maximum aggregate payments to all qualifying hospitals in this group shall not exceed the available upper payment limit per Medicaid State Plan rate year (i.e. federal fiscal year)."

The following questions are being asked and should be answered in relation to all payments made to all providers under Attachment 4.19-A of your State plan.

8. **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.)

Providers retain all of the Medicaid payments, including the federal and State share, for all services provided under Attachment 4.19-A of the State Plan. No portion of the payment is returned to any State or local government entity or any other intermediary organization.

9. **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 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 government 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).

Payments Authorized Under TN 11-022

The State share of funds may eventually come from both State general revenue appropriated by the South Carolina Legislature to SCDHHS and from voluntary IGTs from subdivisions of the State such as units of local government. Currently, the only governmental entity that intends to participate is Spartanburg Regional Health Services District. Any IGT from Spartanburg Regional Health Services District or any other unit of local government will represent public funds eligible for use as the State share of Medicaid payments under federal law. For Federal Fiscal Year 2012, the estimated State share of supplemental Medicaid payments to hospitals is

approximately $18.52 million. Based on the South Carolina FMAP for Federal Fiscal Year 2012, the estimated total payment amount to hospitals is approximately $62.23 million. For Federal Fiscal Year 2013, the estimated State share of supplemental Medicaid payments to hospitals is approximately $18.40 million. Based on the South Carolina FMAP for Federal Fiscal Year 2013, the estimated total payment amount to hospitals is approximately $62.23 million.

In regards to the other Medicaid inpatient hospital payments made under Attachment 4.19-A, the following information is being provided:

Inpatient Hospital DRG Payments	State Appropriations to the Medicaid Agency, Provider Taxes, and IGTs from SC Department of Corrections and SC Department of Juvenile Justice Which are State Appropriations
SCDMH Inpatient Hospital FFS Payments and Non-State Owned Governmental Long Term Care Psych Hospitals FFS Payments	CPE Which is State Appropriations to SCDMH and IGTs From the McCord Center
Swing Bed Hospitals - Per Diem Payments	State Appropriations to the Medicaid Agency and Provider Taxes
Administrative Days - Per Diem Payments	State Appropriations to the Medicaid Agency and Provider Taxes
Qualifying Hospitals Inpatient Cost Settlements	State Appropriations to the Medicaid Agency, Provider Taxes, SCDMH CPE Which is State Appropriations, and McCord Center IGTs
DSH Payments	State Appropriations to the Medicaid Agency (Provider Taxes), and SCDMH CPE Which is State Appropriations
Private Psych Hospitals	State Agency IGTs for Private Psych Hospitals Which are State Appropriations to SC State Agencies
Residential Treatment Facilities (RTFs) Per Diem Payments and Retrospective Cost Settlement Payments (For state owned and non-state owned governmental RTFs)	CPE from SCDMH for Their One RTF and State Agency IGTs for Private RTF Providers Which are State Appropriations to SC State Agencies. IGTs From a Non-State Owned Public General Acute Care Hospital.

State Agencies, via IGTs, transfer state appropriations for privately owned freestanding psychiatric hospital services, a limited number of privately owned general acute care hospital services, and privately owned residential treatment facility services. One non-state owned governmental long term care psych hospital provides IGTs to fund its own services.

Additionally, one non-state owned governmental hospital provides IGTs to fund its RTF. State agencies and the two non-state owned governmental hospitals are required to transfer the state matching funds in advance, prior to the private entities identified above or themselves submitting their claims for Medicaid reimbursement. SCDMH certifies (CPEs) their match requirement for their IMD hospitals and their one RTF via the submission of annual provider cost reports. Additionally, the following contract language is included in the SCDMH contracts:

"SCDMH agrees to incur expenditures from state appropriated funds and/or funds derived from tax revenue in an amount at least equal to the non-federal share of the allowable, reasonable and necessary cost for the provision of services to be provided to Medicaid recipients under this contract prior to submitting claims for payment under this contract. Documentation of the non-federal expenditures necessary to support the claims for reimbursement must be maintained by SCDMH and are subject to audit by SCDHHS. SCDHHS may withhold and/or recoup reimbursements if Certified Public Expenditures are not adequately documented. As required by 45 CFR Part 201.5, all funds expended for the non-federal share of this contract must be in compliance with 42 CFR Part 433 Subpart B. Such non-federal funds must be actually expended for the provision of services to be provided under this contract."

Schedules detailing the information requested in items (i) through (v) relating to other Medicaid inpatient hospital payments is enclosed in addition to a schedule detailing an estimate of total expenditures and state share amounts for each type of Medicaid payment (that was submitted via SC 11-026).

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 Federal Fiscal Year 2012, the estimated State share of supplemental Medicaid payments to private hospitals is approximately $6.22 million and the estimated State share of supplemental Medicaid payments to non-state public hospitals is approximately $12.30 million. Based on the South Carolina FMAP for Federal Fiscal Year 2012, the estimated total payment amount to private hospitals is approximately $20.90 million and the estimated total payment amount to non-state public hospitals is approximately $41.33 million. For Federal Fiscal Year 2013, the estimated State share of supplemental Medicaid payments to private hospitals is approximately $6.18 million and the estimated State share of supplemental Medicaid payments to non-state public hospitals is approximately $12.22 million. Based on the South Carolina FMAP for Federal Fiscal Year 2013, the estimated total payment amount to private hospitals is approximately $20.90 million and the estimated total payment amount to non-state public hospitals is approximately $41.33 million.

10. **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.

Under the Medicaid upper payment limit regulation, aggregate inpatient payments to each group of hospitals may not exceed a reasonable estimate of the amount that would be paid for inpatient services under Medicare payment principles. The "reasonable estimate" provision of the regulation allows states flexibility in applying the upper payment limit test. In general, the State is given the option of reimbursing providers for services based on Medicare costs using CMS 2552 Hospital Cost Reporting principles, Medicare Diagnosis Related Groups (DRG) rates, or any other reasonable method of estimating the amount that would be paid for services by Medicare. South Carolina calculates the inpatient UPLs for private and non-state public hospitals using a Medicare DRG-based methodology.

The details and data sources for the calculation are discussed below. Generally, the methodology uses actual Medicare payments received by each hospital, and Medicare discharges for each hospital for the same time period, to determine a Medicare payment per discharge for each hospital. This amount is adjusted for both acuity differences between the Medicare and Medicaid population, as well as inflation between the base year data and the year of the demonstration, to determine the amount Medicare would pay on a per discharge basis for the Medicaid services provided by each hospital during Federal Fiscal Year 2012 (the Demonstration Year). This hospital-specific per-discharge amount is then multiplied by the Medicaid discharges for each hospital to determine the aggregate UPL attributable to that hospital. The State determined the aggregate UPL for each hospital group by summing the aggregate UPL attributable to each hospital within that group. The methodology is slightly different for non-acute care hospitals, based on differences in the Medicare payment methodology for those hospitals. These differences are addressed below.

To estimate the amount of UPL entitlement available for Medicaid payments under TN 11-022 for the Demonstration Year, the State reduced the aggregate UPL by expected Medicaid inpatient payments to each hospital during the Demonstration Year.

The individual components of this calculation are described below:

1. Aggregate UPL

   The State uses the most recent cost report data available from CMS to determine Medicare payments and discharges for each hospital, as reflected in the Healthcare Cost Report Information System (HCRIS). The cost report year the State uses for each hospital is reflected in the demonstration. The State identifies the total Medicare payments to each hospital for the relevant year. The State uses a 12-month period for all hospitals.

   For Medicaid data, the State uses the most recent State Medicaid claims file available. For the Demonstration Year, the State uses Medicaid inpatient fee-for-service claims with an admission date occurring in State Fiscal Year 2011 (July 1, 2010 to June 30, 2011).

General Acute Care Hospitals

The State first identifies the portion of each hospital's Medicare payments that vary based on patient acuity. These payments are DRG payments (E part A lines 1.00, 1.01 and 1.02), outlier payments (E part A line 2.01), IME payments (E part A line 3.24), Medicare DSH payments (E part A line 4.04) and capital payments (E part A line 9.00). For each hospital, the State sums these payments and then adjusts for the differences in acuity between the Medicare and Medicaid patient populations by multiplying the sum by the hospital's ratio of Medicaid case mix index (CMI) to Medicare CMI. The State obtains the Medicare CMI for each hospital from CMS using 2012 CMS files (the acute hospital impact file, the LTAC impact file, or the rehabilitation hospital rate setting file). The State computes the Medicaid CMI by averaging the relative weights for each claim from the State's Medicaid claims file. To determine the relative weight for each claim, the State identifies the CMS-DRG used by the State for each claim to make interim payments, determines the corresponding MS-DRG for that claim based on the crosswalk file published by CMS, and then identifies the Medicare relative weight using the Federal Fiscal Year 2012 relative weight table.

The State then identifies the portion of each hospital's Medicare payments that do not vary based on patient acuity. These payments are Direct Graduate Medical Education (E part A line 11.00), special add-on payments for new technologies (E part A line 11.02), routine service pass-through payments (E part A line 14.00) and ancillary service pass-through payments (E part A line 15.00). The State sums these payments.

The State adds the two components of Medicare payments together for each hospital to determine acuity-adjusted total Medicare payments. The State then inflation-adjusts these total Medicare payments to account for the timing difference between each hospital's most recent cost reporting year available and the Demonstration Year, using the Medicare inpatient market basket adjustments. Specifically, the State determines the number of months from the end of the cost reporting year to the end of the Demonstration Year and, for each month, applies $1/12^{th}$ of the applicable CMS market basket update.

The State then divides this adjusted Medicare payment amount by the hospital's Medicare discharges for the cost reporting period (S-3 part I line 12 column 13) to determine the amount Medicare would pay, on a per discharge basis, for each hospital's Medicaid services.

The State multiplies this per-discharge amount by the Medicaid discharges for each hospital reflected in the State's Medicaid claims file. This amount represents the aggregate UPL attributable to each hospital.

Sole Community Hospitals

The State uses the same methodology for sole community hospitals with one difference. The State determines the amount of acuity-impacted Medicare payments for sole community hospitals by determining which is greater – the sum of the Medicare

payment amounts identified above (DRG, outlier, IME, DSH and capital), or the Medicare hospital-specific amount (E part A line 7.00). The higher number is then acuity-adjusted using the same methodology discussed above (the ratio of Medicaid CMI to Medicare CMI).

Long Term Acute Care Hospitals

The State uses the same methodology for long term acute care hospitals with a few differences. The State determines acuity-impacted Medicare payments to long term acute care hospitals by summing Medicare DRG payments (E-3 part I line 1.02) and Medicare outlier payments (E-3 part I line 1.05). For each hospital, the sum of these Medicare payments is then acuity-adjusted using the same methodology discussed above (the ratio of Medicaid CMI to Medicare CMI). Long term acute care hospitals do not have any Medicare payments that are not based on acuity.

Freestanding Rehabilitation Hospitals

The State uses the same methodology for freestanding rehabilitation hospitals with a few differences. The State determines acuity-impacted Medicare payments to rehabilitation hospitals by summing PPS payments (E-3 part I line 1.02, columns 1 and 1.01), Low Income Percentage payments (E-3 part I line 1.04, columns 1 and 1.01), and outliers payments (E-3 part I line 1.05). For each hospital, the sum of these payments is then acuity-adjusted using a ratio of Medicaid CMI to Medicare Case Mix Group (CMG). The Medicare CMG is obtained from the CMS 2012 rate setting file. Rehabilitation hospitals do not have any Medicare payments which are not based on acuity.

Critical Access Hospitals

Because Critical Access Hospitals are reimbursed under Medicare at 101% of cost, the State determines the Medicaid costs for each hospital by summing the costs associated with each Medicaid claim from the hospital's base year as reflected in the State Medicaid claims file. To determine the aggregate UPL attributable to each hospital, the State multiplies this amount by 101%.

Freestanding Psychiatric Hospitals

Because freestanding psychiatric hospitals are paid by Medicare on a per diem basis, instead of a per discharge basis, the State calculates the Medicare payment per diem for each hospital, adjusted for inflation, and then multiplies this amount by the hospital's allowed Medicaid days to determine the hospital's portion of the aggregate UPL. The State determines the Medicare payments to each freestanding psychiatric hospital by summing PPS payments (E-3 part I line 1.08), outlier payments (E-3 part I line 1.09) and ECT payments (E part I line 1.10).

The sum of the Medicare payments is inflation-adjusted using the same methodology discussed above. The inflation-adjusted Medicare payment amount for each hospital is then divided by total Medicare days for the same period (S-3 part I line 12 column 4) to compute a Medicare per diem payment for each hospital. The Medicare per diem payment amount for each hospital is multiplied by the Medicaid allowed days for that hospital to determine the hospital's portion of the aggregate UPL.

2. Medicaid Payments

The State determines Medicaid payments for each hospital, other than LTACs and freestanding psychiatric hospitals (discussed below), by first determining the allowed Medicaid cost for that hospital from the most recent State Medicaid claims file. The State then multiplies this cost amount by the applicable reimbursement percentage for that hospital for the Demonstration Year, pursuant to the terms of the State Plan, to determine the estimated Medicaid payment amount for that hospital.

LTACs and psychiatric hospitals are reimbursed under a prospective payment system. Therefore, to estimate the Medicaid payments to each hospital for the Demonstration Year, the State started with the total Medicaid payments amount for that hospital from the most recent State Medicaid claims file. The State then multiplied that Medicaid payment amount by a trending factor to account for changes in the reimbursement rate for that hospital between the base data year and the Demonstration Year.

3. Determination of Available UPL

For each hospital group, the estimated Medicaid payments computed in step 2 are subtracted from the aggregate UPL computed in Step 1 to estimate the remaining available aggregate UPL entitlement for payments under TN 11-022 for that group.

11. **Does any governmental provider receive payments that in the aggregate (normal per diem, supplemental, enhanced, other) exceed their reasonable costs of providing services?**

No governmental provider receives payments that in the aggregate exceed the federal rules related to individual provider payments at 42 U.S. 1396r-4(g)(1)(a) and 42 C.F.R. 447.271. Also, no group of hospitals receives payments in the aggregate that exceed the federal rules regulating aggregate payments at 42 C.F.R. 447.272. The State considers these laws to define reasonable costs for purpose of federal law.

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?

Federal law prohibits the State from paying providers an amount greater than the federal limits discussed in response to Question #11 above. If payments exceed federal limits, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.

The Patient Protection and Affordable Care Act (PL 111-148) imposes certain requirements that can impact federal financial participation in a State's Medicaid program:

12. **Under section 1902(gg) of the Act, as amended by the Affordable Care Act, as a condition of receiving any Federal payments under the Medicaid program during the MOE period indicated below, the State shall not have in effect any eligibility standards, methodologies, or procedures in its Medicaid program which are more restrictive than such eligibility provisions as in effect in its Medicaid program on March 10, 2010.**

MOE Period.

- **Begins on: March 10, 2010, and**
- **Ends on: The date the Secretary of the Federal Department of Health and Human Services determines an Exchange established by a State under the provisions of section 1311 of the Affordable Care Act is fully operational.**

Is SC in compliance with the conditions of the MOE provision of section 1902(gg) of the Act for continued funding under the Medicaid program?

Yes.

13. **Section 1905(y) and (z) of the Act provides for increased federal medical assistance percentages (FMAP) for expenditures made on or after January 1, 2014 for individuals determined eligible under section 1902(a)(10)(A)(i)(VIII) of the Act. Under section 1905(cc) of the Act, the increased FMAP, under sections 1905(y) and (z) would not be available for States that require local political subdivisions to contribute amounts toward the non-Federal share of the State's expenditures at a greater percentage than would have been required on December 31, 2009.**

Prior to January 1, 2014 States may potentially require contributions by local political subdivisions toward the non-Federal share of the States' expenditures at percentages greater than were required on December 31, 2009. However, because of the provisions of section 1905(cc) of the Act, it is important to determine and document/flag any SPAs/State plans which have such greater percentages prior to the January 1, 2014 date in order to anticipate potential violations and/or appropriate corrective actions by the States and the Federal government.

This SPA would [ ] / would not [ ] violate these provisions, if they remained in effect on or after January 1, 2014.

This SPA would not violate these provisions if they remained in effect on or after January 1, 2014.

14. **Section 1905(aa) of the Act provides for a "disaster-recovery FMAP" increase effective no earlier than January 1, 2011. Under section 1905(cc) of the Act, the increased FMAP under section 1905(aa) of the Act is not available for States that require local political subdivisions to contribute amounts toward the non-Federal share of the State's expenditures at a greater percentage than would have been required on December 31, 2009.**

This SPA would [ ] / would not [ ] qualify for such increased federal financial participation (FFP) and is not in violation of this requirement.

The SPA would not qualify for such increased FMAP and is not in violation of this requirement.

15. **Does TN 11-022 comply with the requirements of section 1902(a)(37) of the Act regarding prompt payment of claims?**

Yes.

CONCLUSION

Based on our due diligence regarding the ever expanding interpretation of which types of expanded care services a private hospital can provide without creating a provider donation, it does not appear that CoPs and Certifications from similar programs in other states are adequate to guard against prohibited provider donations and the redirection of Medicaid funds to pay for non-Medicaid services. Consequently, in addition to adopting the same restrictions utilized by Texas, Louisiana and Nevada, SCDHHS expanded its CoPs and Certifications to clearly delineate restrictions on what types of services private hospitals may provide, what relationships between private providers and governmental entities are appropriate, how Medicaid funds can be used, and to require the submission of all financial relationships between the Affiliated Private Hospitals and the GE or Affiliated Public Hospitals. Therefore, in order to assuage CMS' concerns, South Carolina implemented the following added protections from those approved by CMS in Texas, Louisiana and Nevada:

(1) SCDHHS added language in both the Affiliated Private Hospital Certification and the Governmental Entity Certification that explicitly prohibits a GE or non-state public hospital owned or operated by that GE from having any ownership interest in any entity that any Affiliated Private Hospitals establish to more efficiently deliver expanded charity care.[28]

(2) SCDHHS added provisions in both the Affiliated Private Hospital Certification and the Governmental Entity Certification that require Affiliated Private Hospitals, GEs, and Affiliated Public Hospitals to list all transactions and agreements between the Affiliated Private Hospitals and the GEs or Affiliated Public Hospitals at the time they enter into a Collaboration Agreement—and to continually supplement that list over the course of

28 Attachment C, Section 2(c)(v); Attachment D, Section 4(h).

their collaboration.[29] We are also requiring all Affiliated Private Hospitals, GEs and Affiliated Public Hospitals to certify that any transfers and transactions between the Affiliated Private Hospitals and GEs or Affiliated Public Hospitals are unrelated to the delivery of low income and needy patient care under their Collaboration Agreement, or the administration of the Affiliated Private Hospitals' provision of low income and needy care in the community served by the GE and Affiliated Public Hospital.[30] This transparency, which to our knowledge is unprecedented in similar programs, will prevent GEs or Affiliated Public Hospitals and Affiliated Private Hospitals from entering into ancillary agreements to be used as a vehicle to effectuate indirect provider donations.

(3) SCDHHS added language to the CoPs to prohibit Affiliated Private Hospitals from assuming the operational costs of a GE or Affiliated Public Hospital as part of their collaboration in order to address CMS' specific concern on this issue, and delineated specific operational costs of a GE and Affiliated Public Hospital that cannot be provided by a private hospital without creating a provider donation.[31]

(4) SCDHHS changed the CoPs and Certifications to prohibit the use of escrow accounts or other funding mechanisms as part of the collaboration program.[32] We also required any IGT to originate from the general revenue of a GE.[33]

(5) SCDHHS is willing to submit Collaboration Agreements and any documents related to the collaboration to CMS for review before making supplemental payments to hospitals under TN 11-022.

With these additional safeguards in place, coupled with the safeguards already established under the expanded care collaboration model as outlined above, we believe that TN 11-022 is fully compliant with all federal and State laws. Please let us know if you have any questions or need any additional information regarding TN 11-022.

Sincerely,

Anthony E. Keck
Director
Department of Health and Human Services

Enclosures

29 Attachment C, Section 4(b); Attachment D, Section 2(c).
30 Attachment C, Section 2(c)(vi); Attachment D, Section 4(i).
31 Attachment B, Section I.
32 Attachment B, Section I(b)(3); Attachment C, Section 2(c); Attachment D, Section 4(d).
33 Attachment D, Section 4(d).

ATTACHMENT A

Low Income and Needy Patient Care Collaboration Agreement

ATTACHMENT B

Conditions of Participation

ATTACHMENT C

Affiliated Private Hospital Certification

ATTACHMENT D

Governmental Entity Certification

ATTACHMENT E
Services DHHS Envisions Private Hospitals Will Provide as Part of Their Charity Care Expansion Under Collaboration Agreements

Examples of the types of low income and needy patient care services we expect the Affiliated Private Hospitals will provide include the expansion of many services they already provide, as well as services not typically provided by hospitals. The service types we have identified up to this point as potentially viable to be provided by private hospitals without creating a provider donation include, but are not limited to:

- treatment and support to patients with mental illnesses and addictive disorders (e.g. face-to-face crisis screening, in-home crisis stabilization, mental health treatment, outreach, monitoring, case management, crisis management, medication management, service and benefit coordination, addiction counseling, relapse prevention training, skills training, financial management and budgeting, assistance in obtaining and maintaining employment or other meaningful daily activities, assistance in utilizing public transportation and direct assistance with family);
- housing/residential services for patients with serious mental illnesses (including basic board and care, assistance with personal care needs, monitoring of self-medication, and developing and implementing an individual service plan for each patient that may include rental subsidies, assisting with obtaining and maintaining permanent housing, increasing tenancy skills, and achieving a greater self-determination which results in sustained levels of community living);
- alcohol and drug abuse treatment and rehabilitation services;
- tobacco and other healthcare-related prevention services;
- residency program and healthcare education services;
- primary and specialty physician services;
- emergency and on-call physician services;
- kidney dialysis services;
- dentistry and oral surgery services;
- ophthalmology services;
- optometry services;
- pharmaceutical services;
- radiology services;
- CRNA services;
- radiation oncology services;
- nursing hotline services;
- air ambulance services;
- professional healthcare recruiting services for medical shortage areas;
- health clinic services;
- laboratory services;
- perfusionist services; and
- inpatient and outpatient hospital services.

ATTACHMENT F

Management Services Agreement

ATTACHMENT G

Public Notice for TN 11-022

ATTACHMENT J

Updated TN 11-022

Log 283
RAI Responses
Submitted to
CMS on 12/28/12