DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Myers/Singleton	12/22/10

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 00271	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR cc: Ms. Forkner, Jacobs, Wells Cleared 1/10/11, Bulletin attached, dated 12/14/10	[X] Prepare reply for appropriate signature DATE DUE 1-7-11 [ ] 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.			* Please coordinate response. Also note from Emma below.
2.			
3.			
4.			

* May require Bulletin to clarify - when ready to implement.

PROTECTION & ADVOCACY FOR PEOPLE
WITH DISABILITIES, INC.
3710 LANDMARK DRIVE, SUITE 208
COLUMBIA, SC 29204
FAX (803) 790-1946 PHONE (803)782-0639

FACSIMILE TRANSMITTAL SHEET

TO:	FROM:
Emma Forknet, Director	Sarah St. Onge /sg
COMPANY: SC Department of Health and Human Services	DATE: 12/21/10
FAX NUMBER 803-255-8235	TOTAL NO. OF PAGES INCLUDING COVER: 6
PHONE NUMBER:	

RE: Cuts to Private Rehabilitative Services and EPSDT

☐ URGENT ☐ FOR REVIEW ☒ HARD COPY OF ATTACHED TO FOLLOW BY U.S. MAIL

NOTES/COMMENTS:

Letter and enclosure

RECEIVED
DEC 2 1 2010
~~MEDICAID ELIGIBILITY & BENEFICIARY SERVICES~~
Director's Office

PROTECTION AND ADVOCACY FOR PEOPLE WITH DISABILITIES, INC

The Protection & Advocacy System for South Carolina

December 21, 2010

VIA FACSIMILE (803-255-8235 and 803-255-8210) and U.S. MAIL

Emma Forkner, Director
S.C. Dept. of Health and Human Services
P.O. Box 8206
Columbia, SC 29202-8206

Re: Cuts to Private Rehabilitative Services and EPSDT

Dear Ms. Forkner:

I am writing in response to the Medicaid changes brought before the Medical Care Advisory Committee on December 10 and outlined in the December 14 Medicaid Bulletin to Providers. P&A is specifically concerned about the part of the Medicaid Bulletin that states, "Individuals under 21 years of age can only receive a combined total of 75 visits per year for private rehabilitative services . . . ." The language incorrectly indicates an absolute cap on those services regardless of need, and fails to set out any process for exceeding the cap.

Because the Medicaid Bulletin failed to make it clear that the caps may be exceeded under certain circumstances, the indication that the caps are absolute is being further disseminated by at least one other agency. At the DDSN Commission meeting on December 16, Dr. Buscemi stated that the 75 visit limit applied to everyone on Medicaid. Dr. Buscemi made it clear that DDSN considers the 75 limit to be a complete limit on the number of private rehabilitative therapy visits. On December 16 DDSN issued a letter to providers, much like the Medicaid Bulletin issued by DHHS two days earlier, that describes the cuts and does not clarify that they can be exceeded in certain circumstances; it states, "A cap of a combined total of 75 visits per year for private SPL/PT/OT (versus unlimited)." (The DDSN Memorandum is available at http://ddsn.sc.gov/about/recentnews/Documents/Medicaid%20Reductions%20and%20Changes.pdf). It was also stated at the meeting that DHHS is issuing a similar letter to recipients notifying them of the cuts.

In order to learn whether DHHS was creating an absolute cap, P&A contacted Richard Hepfer, in the Office of General Counsel, who offered guidance that the cap is not absolute and, therefore, complies with federal law. In other words, we have been told that the limits to the number of private rehabilitative visits for Medicaid beneficiaries under the age of 21 are tentative, because

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under EPSDT the state cannot limit the amount of medically necessary services provided to Medicaid eligible children. While such guidance is reassuring, it is meaningless as long as DHHS is disseminating information that indicates an absolute cap has been created. DHHS must immediately clarify that the cap may be exceeded and the process for exceeding the cap. The entitlement to medically necessary services as well as the process to receive those services must be disseminated to providers and to recipients of services in order to comply with federal law.

42 U.S.C. § 1396a(a)(43) states:

> A State plan for medical assistance must provide for— informing all persons in the State who are under the age of 21 and who have been determined to be eligible for medical assistance including services described in section 1396d (a)(4)(B) of this title, of the availability of early and periodic screening, diagnostic, and treatment services as described in section 1396d (r) of this title....

Case law makes it clear that a simple brochure mentioning EPSDT and encouraging screenings is not sufficient to comply with 42 U.S.C. § 1396a(a)(43). *See John B. v. Menke*, 176 F. Supp. 2d 786, 792 (M.D. Tenn. 2001)(Consent decree required "aggressively and effectively [informing] enrollees of the existence of the EPSDT program, including the availability of specific EPSDT screening and treatment services."); *Salazar v. D.C.*, 954 F. Supp. 278, 331-33 (D.D.C. 1996). In this particular circumstance, making general information about EPSDT available is inadequate to clarify that individuals are entitled to more than 75 medically necessary visits, when the specific information from the agency is that "only" 75 visits per year are allowed. EPSDT requires states to encourage, not discourage, access to medically necessary services.

As the single state Medicaid agency, DHHS is responsible for ensuring that applicants and recipients are aware of the services that are available through EPSDT. To comply with federal law, DHHS must notify recipients and providers (a) that the caps are guidelines that do not apply if the therapy has been determined to be medically necessary by a medical professional and is being provided by a qualified provider and (b) the process for exceeding the caps.

Enclosed is a notice to inform recipients and providers of individuals' rights under EPSDT, which has been prepared by P&A. P&A intends to disseminate this notice as soon as January 3, 2011, and as broadly as possible. If you disagree with the statement of the law contained in the notice, please let me know as soon as possible. If you agree with the statement of the law, then it is DHHS' responsibility to also disseminate this information to providers and recipients. If such information has already been disseminated to either providers or recipients, please provide us with a copy of what has been sent and to whom it has been sent.

P&A also requests clarification of two other issues. First, P&A received information that the 75 visit cap will be retroactive to July 1, 2010. In other words, on February 1, 2011, when the cap

goes into effect, some individuals may have already exceeded the cap, meaning they could be without any therapy until July 1, 2011. Such an abrupt disruption to their prescribed therapy could cause regression or medical complications. Retroactive caps were not discussed at either the Medical Care Advisory Committee meeting December 10 or at the DDSN Commission meeting. The December 14 Medicaid Bulletin refers only to changes effective February 1. Please clarify whether the limits are retroactive and, if so, how parents will be notified that they are approaching the cap's limits and about their appeal rights.

Second, do the caps affect those individuals who receive their services through a managed care organization (MCO)? If so, how will the MCOs comply with the law and provide for exceptions to any caps they may have? How will DHHS monitor the MCOs' compliance?

P&A has shared its concern about the effect of these cuts with South Carolina Legal Services and South Carolina Appleseed Legal Justice Center. All three entities, as providers of legal services to individuals who have disabilities and are receiving services through Medicaid, support the actions requested by this letter.

Given the quickly approaching implementation of the cap and the possible retroactivity of the change, it is essential to provide correct information about the process for exceeding 75 visits immediately in order for HHS to be in compliance with federal law.

This clarification needs to be distributed by January 10. I appreciate your help and your attention to this matter. You may reach me by email at stonge@pandasc.org or by phone at 803-217-6706.

Sincerely,

Sarah St. Onge
Attorney at Law

cc: Anna Maria Darwin, Esq.
Gloria Prevost
Dan Unumb, Esq., South Carolina Legal Services
Sue Berkowitz, Esq., South Carolina Appleseed Legal Justice Center
Victoria Wachino, Centers for Medicare & Medicaid Services
Richard Hepfer, Esq., SCDHHS

Enclosure

PROTECTION AND ADVOCACY FOR PEOPLE WITH DISABILITIES, INC.

January 3, 2011

Re: NOTICE REGARDING MEDICAID REDUCTIONS FOR CHILDREN UNDER 21

Dear Medicaid Recipients under the age of 21, Parents and Guardians, and Medicaid Providers:

Protection and Advocacy for People with Disabilities, Inc. (P&A) is a private, non-profit organization mandated by state and federal law to protect the rights of people with disabilities. P&A wants you to know some important information about Medicaid that may affect children under 21.

The South Carolina Department of Health and Human Services (SCDHHS) recently sent out a Medicaid Bulletin dated December 14, 2010, about upcoming Medicaid Reductions. This bulletin contained some confusing information regarding cuts to services for individuals under the age of 21 years old. P&A, with the support of South Carolina Legal Services and South Carolina Appleseed Legal Justice Center, has asked SCDHHS to clarify information about the reductions and explain the federal law regarding Medicaid services for children. Since we do not know if or when SCDHHS will provide this clarification, we wanted to offer this information to help you understand your child/patient's rights under federal Medicaid law so that you can access the necessary medical services.

According to federal law, any state that participates in the Medicaid program must provide certain mandatory services for children.[1] The federal government refers to these services as Early and Periodic Screening, Diagnosis, and Treatment (EPSDT).[2] Specifically, every state's Medicaid program must cover "necessary health care, diagnostic services, treatment…to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the state plan."[3]

In plain language, EPSDT requires that a state cover ALL medically necessary services for children that fall under a category of assistance that Medicaid provides. Even if it is not covered in the state plan, if it is a service that could be covered by Medicaid and it is medically necessary, then the state Medicaid agency MUST cover it.

Therefore, SCDHHS cannot legally refuse to cover certain medical supplies for children or limit the number of doctor visits or therapy services per year, if the assistance is in fact medically

[1] 42 U.S.C. 1396 (a)
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[3] 42 U.S.C. 1396d (r)(5)

necessary. SCDHHS must look at the treating physician's recommendation and the medical documentation to decide if a service is medically necessary.[4]

We know that many children who receive Medicaid currently need multiple types of therapy. One of the new Medicaid cuts set to begin February 1, 2011, is a reduction in the number of rehabilitative therapy visits covered per year. SCDHHS has not explained that this "cap" on therapy services for children actually does not prevent children from getting therapies that are medically necessary. SCDHHS must allow exceptions to this cap when medically necessary. It must also provide adequate notice and set up procedures for parents of affected individuals to access the services they require in excess of the "cap."

If you or your child is a Medicaid recipient under the age of 21 who needs services that are affected by the recent cuts, ask your provider to contact the Medicaid office immediately to find out how to request Prior Authorization for an exception to the reductions. If SCDHHS refuses to accept the request, or if the request is denied but you feel the service is medically necessary, then please contact P&A for assistance. While P&A cannot represent providers, they are encouraged to let us know if they encounter difficulties in obtaining authorization for services.

P&A's services are free. Our toll-free number is 1-866-275-7273 or email to info@pandasc.org.

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December 21, 2010

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

RECEIVED
DEC 23 2010
SCDHHS
Office of General Counsel

ACTION REFERRAL

TO	DATE
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APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
1. Rut 1/13/11			* Please coordinate response. Also note from Emma below.
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4.			

* May require Bulletin to clarify - when ready to implement.

South Carolina Department of
Health & Human Services

Emma Forkner • Director
Mark Sanford• Governor

January 14, 2011

Sarah St. Onge
Attorney at Law
Protection and Advocacy for
People with Disabilities
3710 Landmark Dr., Suite 208
Columbia, SC 29204

Re: Cuts to Private Rehabilitation Services and EPSDT

Dear Ms. St. Onge:

Your letter to Ms. Forkner on the above subject was referred to this Office for a response. It is unfortunate that providers interpreted the combined totals language in the recent Medicaid Bulletin to indicate an absolute cap on rehabilitative services. We were surprised as we indicated to you because their provider manual clearly specifies the process to request an override of the limits when necessary. We appreciate your bringing the confusion to our attention, and we plan to issue another provider Bulletin more clearly outlining the process.

We understand that your notice has been sent out, and although we do not completely agree with the characterization of EPSDT services in the draft provided, you certainly may advise your clients as you see fit. In this case, we believe that the most practical benefit for eligible children will come from issuing a clarification to providers, who often broker services to recipients.

As far as general compliance with 42 U.S.C. §1396a(a)(43), we believe that the Department is in compliance with that provision. We have set up a number of things to actively inform recipients of EPSDT services, including:

- The Application contains a notice of the service;
- When the Medicaid card is mailed, recipients receive a Handbook of Benefits, which describes the EPSDT Service.
- All Newsletters contain a notice about the service;
- Upon redetermination of eligibility (annually) notice is again presented to the recipient;

Of course we do not see EPSDT services as expansively as do you all. However, although we will consider your comments when drafting future announcements, we believe our overall approach to notifying recipients of this service is designed to adequately encourage parents to see that children receive the recommended screenings and obtain medically necessary ameliorative treatments.

As always, thank you for your interest in these matters and please contact me if you would like to discuss the further. My direct is (803) 898-2791.

Sincerely,

Richard G. Hepfer
Deputy General Counsel

cc: Emma Forkner

OFFICE OF GENERAL COUNSEL
P.O. Box 8206 • Columbia, South Carolina 29202-8206
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PROTECTION AND ADVOCACY FOR PEOPLE WITH DISABILITIES, INC

The Protection & Advocacy System for South Carolina

December 21, 2010

VIA FACSIMILE (803-255-8235 and 803-255-8210) and U.S. MAIL

Emma Forkner, Director
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1569 SAM RITTENBERG BLVD.
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(843) 763-8571
1-800-743-2553
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under EPSDT the state cannot limit the amount of medically necessary services provided to Medicaid eligible children. While such guidance is reassuring, it is meaningless as long as DHHS is disseminating information that indicates an absolute cap has been created. DHHS must immediately clarify that the cap may be exceeded and the process for exceeding the cap. The entitlement to medically necessary services as well as the process to receive those services must be disseminated to providers and to recipients of services in order to comply with federal law.

42 U.S.C. § 1396a(a)(43) states:

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Enclosed is a notice to inform recipients and providers of individuals' rights under EPSDT, which has been prepared by P&A. P&A intends to disseminate this notice as soon as January 3, 2011, and as broadly as possible. If you disagree with the statement of the law contained in the notice, please let me know as soon as possible. If you agree with the statement of the law, then it is DHHS' responsibility to also disseminate this information to providers and recipients. If such information has already been disseminated to either providers or recipients, please provide us with a copy of what has been sent and to whom it has been sent.

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goes into effect, some individuals may have already exceeded the cap, meaning they could be without any therapy until July 1, 2011. Such an abrupt disruption to their prescribed therapy could cause regression or medical complications. Retroactive caps were not discussed at either the Medical Care Advisory Committee meeting December 10 or at the DDSN Commission meeting. The December 14 Medicaid Bulletin refers only to changes effective February 1. Please clarify whether the limits are retroactive and, if so, how parents will be notified that they are approaching the cap's limits and about their appeal rights.

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P&A has shared its concern about the effect of these cuts with South Carolina Legal Services and South Carolina Appleseed Legal Justice Center. All three entities, as providers of legal services to individuals who have disabilities and are receiving services through Medicaid, support the actions requested by this letter.

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This clarification needs to be distributed by January 10. I appreciate your help and your attention to this matter. You may reach me by email at stonge@pandasc.org or by phone at 803-217-6706.

Sincerely,

Sarah St. Onge
Attorney at Law

cc: Anna Maria Darwin, Esq.
Gloria Prevost
Dan Unumb, Esq., South Carolina Legal Services
Sue Berkowitz, Esq., South Carolina Appleseed Legal Justice Center
Victoria Wachino, Centers for Medicare & Medicaid Services
Richard Hepfer, Esq., SCDHHS

Enclosure

PROTECTION AND ADVOCACY FOR PEOPLE WITH DISABILITIES, INC.

January 3, 2011

Re: NOTICE REGARDING MEDICAID REDUCTIONS FOR CHILDREN UNDER 21

Dear Medicaid Recipients under the age of 21, Parents and Guardians, and Medicaid Providers:

Protection and Advocacy for People with Disabilities, Inc. (P&A) is a private, non-profit organization mandated by state and federal law to protect the rights of people with disabilities. P&A wants you to know some important information about Medicaid that may affect children under 21.

The South Carolina Department of Health and Human Services (SCDHHS) recently sent out a Medicaid Bulletin dated December 14, 2010, about upcoming Medicaid Reductions. This bulletin contained some confusing information regarding cuts to services for individuals under the age of 21 years old. P&A, with the support of South Carolina Legal Services and South Carolina Appleseed Legal Justice Center, has asked SCDHHS to clarify information about the reductions and explain the federal law regarding Medicaid services for children. Since we do not know if or when SCDHHS will provide this clarification, we wanted to offer this information to help you understand your child/patient's rights under federal Medicaid law so that you can access the necessary medical services.

According to federal law, any state that participates in the Medicaid program must provide certain mandatory services for children.[1] The federal government refers to these services as Early and Periodic Screening, Diagnosis, and Treatment (EPSDT).[2] Specifically, every state's Medicaid program must cover "necessary health care, diagnostic services, treatment…to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the state plan."[3]

In plain language, EPSDT requires that a state cover ALL medically necessary services for children that fall under a category of assistance that Medicaid provides. Even if it is not covered in the state plan, if it is a service that could be covered by Medicaid and it is medically necessary, then the state Medicaid agency MUST cover it.

Therefore, SCDHHS cannot legally refuse to cover certain medical supplies for children or limit the number of doctor visits or therapy services per year, if the assistance is in fact medically

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[1] 42 U.S.C. 1396 (a)
[2] 42 U.S.C. 1396d (r)
[3] 42 U.S.C. 1396d (r)(5)

necessary. SCDHHS must look at the treating physician's recommendation and the medical documentation to decide if a service is medically necessary.[4]

We know that many children who receive Medicaid currently need multiple types of therapy. One of the new Medicaid cuts set to begin February 1, 2011, is a reduction in the number of rehabilitative therapy visits covered per year. SCDHHS has not explained that this "cap" on therapy services for children actually does not prevent children from getting therapies that are medically necessary. SCDHHS must allow exceptions to this cap when medically necessary. It must also provide adequate notice and set up procedures for parents of affected individuals to access the services they require in excess of the "cap."

If you or your child is a Medicaid recipient under the age of 21 who needs services that are affected by the recent cuts, ask your provider to contact the Medicaid office immediately to find out how to request Prior Authorization for an exception to the reductions. If SCDHHS refuses to accept the request, or if the request is denied but you feel the service is medically necessary, then please contact P&A for assistance. While P&A cannot represent providers, they are encouraged to let us know if they encounter difficulties in obtaining authorization for services.

P&A's services are free. Our toll-free number is 1-866-275-7273 or email to info@pandasc.org.

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reference provider manual EPSDT — this cap can be overridden if MD determines medically necessary.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Myers/Singleton	12/22/10

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 001271	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR cc: Ms. Forkner, Jacobs, Wells	[X] Prepare reply for appropriate signature DATE DUE 1-7-11
	[ ] 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.	DONE		*Please coordinate response. Also note from Emma below.
2.			
3.			
4.			

email jackie glaze

*May require Bulletin to clarify - when ready to implement.

PROTECTION & ADVOCACY FOR PEOPLE
WITH DISABILITIES, INC.
3710 LANDMARK DRIVE, SUITE 208
COLUMBIA, SC 29204
FAX (803) 790-1946 PHONE (803)782-0639

FACSIMILE TRANSMITTAL SHEET

TO: Emma Forkner, Director	FROM: Sarah St. Onge /sg
COMPANY: SC Department of Health and Human Services	DATE: 12/21/10
FAX NUMBER 803-255-8235	TOTAL NO. OF PAGES INCLUDING COVER: 6
PHONE NUMBER:	
RE: Cuts to Private Rehabilitative Services and EPSDT	

☐ URGENT ☐ FOR REVIEW ☒ HARD COPY OF ATTACHED TO FOLLOW BY U.S. MAIL

NOTES/COMMENTS:

Letter and enclosure

RECEIVED
DEC 2 1 2010
~~MEDICAID ELIGIBILITY & BENEFICIARY SERVICES~~
Director's Office

PROTECTION AND ADVOCACY FOR PEOPLE WITH DISABILITIES, INC

The Protection & Advocacy System for South Carolina

December 21, 2010

VIA FACSIMILE (803-255-8235 and 803-255-8210) and U.S. MAIL

Emma Forkner, Director
S.C. Dept. of Health and Human Services
P.O. Box 8206
Columbia, SC 29202-8206

Re: Cuts to Private Rehabilitative Services and EPSDT

Dear Ms. Forkner:

I am writing in response to the Medicaid changes brought before the Medical Care Advisory Committee on December 10 and outlined in the December 14 Medicaid Bulletin to Providers. P&A is specifically concerned about the part of the Medicaid Bulletin that states, "Individuals under 21 years of age can only receive a combined total of 75 visits per year for private rehabilitative services . . . ." The language incorrectly indicates an absolute cap on those services regardless of need, and fails to set out any process for exceeding the cap.

Because the Medicaid Bulletin failed to make it clear that the caps may be exceeded under certain circumstances, the indication that the caps are absolute is being further disseminated by at least one other agency. At the DDSN Commission meeting on December 16, Dr. Buscemi stated that the 75 visit limit applied to everyone on Medicaid. Dr. Buscemi made it clear that DDSN considers the 75 limit to be a complete limit on the number of private rehabilitative therapy visits. On December 16 DDSN issued a letter to providers, much like the Medicaid Bulletin issued by DHHS two days earlier, that describes the cuts and does not clarify that they can be exceeded in certain circumstances; it states, "A cap of a combined total of 75 visits per year for private SPL/PT/OT (versus unlimited)." (The DDSN Memorandum is available at http://ddsn.sc.gov/about/recentnews/Documents/Medicaid%20Reductions%20and%20Changes.pdf). It was also stated at the meeting that DHHS is issuing a similar letter to recipients notifying them of the cuts.

In order to learn whether DHHS was creating an absolute cap, P&A contacted Richard Hepfer, in the Office of General Counsel, who offered guidance that the cap is not absolute and, therefore, complies with federal law. In other words, we have been told that the limits to the number of private rehabilitative visits for Medicaid beneficiaries under the age of 21 are tentative, because

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Attorney at Law

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Enclosure

PROTECTION AND ADVOCACY FOR PEOPLE WITH DISABILITIES, INC.

January 3, 2011

Re: NOTICE REGARDING MEDICAID REDUCTIONS FOR CHILDREN UNDER 21

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PROTECTION AND ADVOCACY FOR PEOPLE WITH DISABILITIES, INC

The Protection & Advocacy System for South Carolina

December 21, 2010

VIA FACSIMILE (803-255-8235 and 803-255-8210) and U.S. MAIL

Emma Forkner, Director
S.C. Dept. of Health and Human Services
P.O. Box 8206
Columbia, SC 29202-8206

Re: Cuts to Private Rehabilitative Services and EPSDT

Dear Ms. Forkner:

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Protection and Advocacy for People with Disabilities, Inc. (P&A) is a private, non-profit organization mandated by state and federal law to protect the rights of people with disabilities. P&A wants you to know some important information about Medicaid that may affect children under 21.

The South Carolina Department of Health and Human Services (SCDHHS) recently sent out a Medicaid Bulletin dated December 14, 2010, about upcoming Medicaid Reductions. This bulletin contained some confusing information regarding cuts to services for individuals under the age of 21 years old. P&A, with the support of South Carolina Legal Services and South Carolina Appleseed Legal Justice Center, has asked SCDHHS to clarify information about the reductions and explain the federal law regarding Medicaid services for children. Since we do not know if or when SCDHHS will provide this clarification, we wanted to offer this information to help you understand your child/patient's rights under federal Medicaid law so that you can access the necessary medical services.

According to federal law, any state that participates in the Medicaid program must provide certain mandatory services for children.[1] The federal government refers to these services as Early and Periodic Screening, Diagnosis, and Treatment (EPSDT).[2] Specifically, every state's Medicaid program must cover "necessary health care, diagnostic services, treatment…to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the state plan."[3]

In plain language, EPSDT requires that a state cover ALL medically necessary services for children that fall under a category of assistance that Medicaid provides. Even if it is not covered in the state plan, if it is a service that could be covered by Medicaid and it is medically necessary, then the state Medicaid agency MUST cover it.

Therefore, SCDHHS cannot legally refuse to cover certain medical supplies for children or limit the number of doctor visits or therapy services per year, if the assistance is in fact medically

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[1] 42 U.S.C. 1396 (a)
[2] 42 U.S.C. 1396d (r)
[3] 42 U.S.C. 1396d (r)(5)

necessary. SCDHHS must look at the treating physician's recommendation and the medical documentation to decide if a service is medically necessary.[4]

We know that many children who receive Medicaid currently need multiple types of therapy. One of the new Medicaid cuts set to begin February 1, 2011, is a reduction in the number of rehabilitative therapy visits covered per year. SCDHHS has not explained that this "cap" on therapy services for children actually does not prevent children from getting therapies that are medically necessary. SCDHHS must allow exceptions to this cap when medically necessary. It must also provide adequate notice and set up procedures for parents of affected individuals to access the services they require in excess of the "cap."

If you or your child is a Medicaid recipient under the age of 21 who needs services that are affected by the recent cuts, ask your provider to contact the Medicaid office immediately to find out how to request Prior Authorization for an exception to the reductions. If SCDHHS refuses to accept the request, or if the request is denied but you feel the service is medically necessary, then please contact P&A for assistance. While P&A cannot represent providers, they are encouraged to let us know if they encounter difficulties in obtaining authorization for services.

P&A's services are free. Our toll-free number is 1-866-275-7273 or email to info@pandasc.org.

[4] *See Moore ex rel. Moore v. Medows*, 674 F. Supp. 2d 1366, 1370-1371 (N.D. Ga. 2009)(citing to *Collins v. Hamilton*,349 F.3d 371, 375 n. 8 (7th Cir.2003) (a state's discretion to exclude services deemed "medically necessary" by an EPSDT provider has been circumscribed by the express mandate of the statute); *Pediatric Specialty Care, Inc. v. Arkansas Dept. of Human Servs.*, 293 F.3d 472, 480 (8th Cir.2002) (finding that a state must pay for costs of treatment found to ameliorate conditions discovered by EPSDT screenings if such treatments are listed in section 1396d(a)); and *Pereira v. Kozlowski*, 996 F.2d 723, 725-26 (4th Cir.1993)).

South Carolina
DEPARTMENT OF HEALTH AND HUMAN SERVICES
Post Office Box 8206
Columbia, South Carolina 29202-8206
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December 14, 2010

ALL

MEDICAID BULLETIN

To: **Medicaid Providers**

Subject: **Medicaid Reductions**

The South Carolina Department of Health and Human Services (SCDHHS) projects a budget shortfall of $228 million during the current fiscal year. This is a result of a combination of significant enrollment increases and budget reductions. In order to safeguard the financial viability of the Medicaid program and meet statutory requirements for the operation of Medicaid, SCDHHS must take prompt action to contain Medicaid costs. Current state and federal restrictions largely limit the agency's ability to make reductions apart from reducing optional state Medicaid services.

Below is a list of upcoming changes. Additional Medicaid Bulletins may be issued to provide further details. To learn more about South Carolina's Medicaid budget, current restrictions and to offer cost-saving suggestions, please visit http://msp.scdhhs.gov/msp.

INDEX:

1. **The following eliminations are effective for dates of service on or after February 1, 2011:**

- **Discontinue Coverage of Podiatry services for adults**
  SCDHHS will discontinue coverage of Podiatric services for beneficiaries over the age of 21.

- **Discontinue Coverage of Vision services for adults**
  SCDHHS will discontinue coverage of Vision services for beneficiaries over the age of 21. Those services affected by this change include routine eye exams and refraction as well as glasses that fall within the policy limitation. Medically necessary vision services will continue to be covered. Payment of these services are subject to review by the SCDHHS Program Integrity Division.

- **Discontinue Coverage of Dental services for adults**
  Dental services currently covered under the State Plan for beneficiaries aged 21 or older will no longer be covered, regardless of setting.

- **Discontinue Coverage of Hospice care services for adults**

- **Discontinue Coverage of routine newborn circumcisions**
  SCDHHS will no longer cover routine newborn circumcisions. Medically necessary circumcisions will continue to be covered for all male beneficiaries but must receive prior approval. For additional information on this policy update, please refer to the Physicians, Laboratories, and Other Medical Professionals Manual. The most current versions of the provider manuals are maintained on the SCDHHS website at www.scdhhs.gov.

- **Discontinue Coverage for Insulin Pumps for Type II Diabetics**
  SCDHHS will only cover Insulin pumps for Type I Diabetics. For additional information on this policy update, please refer to the Durable Medical Equipment Manual. The most current versions of the provider manuals are maintained on the SCDHHS website at www.scdhhs.gov.

- **Discontinue Coverage of Syvek patch**

- **Discontinue Coverage of wheelchair accessories such as umbrella holder, pillows and crutch/cane holder**
  SCDHHS will discontinue coverage of all non-medically necessary wheelchair accessories which include but are not limited to crutch/cane holders, umbrella holder, and similar accessories.

2. **The following reductions are effective for dates of service on or after February 1, 2011:**

- Diabetic shoes will be reduced from two pairs per year to one
- Diabetic shoe inserts will be reduced from six per year to three
- Home health visits will be reduced from 75 visits to 50 visits per year
- Individuals under 21 years of age can only receive a combined total of 75 visits per year for private rehabilitative services (speech and language therapy, occupational therapy or physical therapy)
- Chiropractic services will be reduced from eight visits to six visits per year
- Adult pharmacy overrides will be reduced from four per month to three
- Power wheelchairs will be replaced every seven years instead of five
- Adult behavioral health services will be limited to 12 outpatient visits per year

3. **The following service eliminations for the Community Long Term Care (CLTC) Program are effective for dates of service on or after April 1, 2011:**

   - Chore service
   - Appliance service
   - Nutritional supplements
   - Adult day health care nursing service
   - Respite service

4. **The following service reduction for the Community Long Term Care (CLTC) Program is effective for dates of service on or after April 1, 2011:**

   - Home delivered meals will be reduced from 14 to 10 meals per week

5. **Increase in Co-Payments Effective for dates of service on or after April 1, 2011:**

   Beginning April 1, 2011, SCDHHS will increase co-pays for certain visits. However, the following categories are exempt from co-pays:

   - Children under 19 years of age
   - Pregnant women
   - Individuals receiving Family Planning services
   - Institutionalized individuals
   - Individuals receiving emergency services
   - Federally-recognized Native Americans

   All other Medicaid beneficiaries will be subject to the following changes:

	Old	New
• Office Visits (Physician, Nurse Practitioner, Licensed Midwife)	$2.00	$2.30
• Chiropractor	$1.00	$1.15
• Home Health	$2.00	$2.30
• Clinic Visits	$2.00	$2.30
• Prescription Drugs	$3.00	$3.40
• Outpatient Hospital	$3.00	$3.40
• Non-Emergent Services in the Emergency Room	$3.00	$3.40
• Medical Equipment and Supplies (co-pay will vary)	$0-3.00	$.60-$3.40

If you have any questions regarding this bulletin or any other Medicaid billing or policy questions, please contact your provider representative. Thank you for your continued support and participation in the South Carolina Medicaid Program.

/s/

Emma Forkner
Director

**NOTE: To receive Medicaid bulletins by email, please register at http://bulletin.scdhhs.gov/.
To sign up for Electronic funds Transfer of your Medicaid payment, please go to:
http://www.dhhs.state.sc.us/dhhsnew/hipaa/index.asp and select "Electronic funds Transfer (EFT)" for instructions.**

Medicaid & You

Mark Sanford, Governor • Emma Forkner, DHHS Director
South Carolina Department of Health and Human Services

Dear Medicaid Beneficiary,

The South Carolina Department of Health and Human Services must make changes to the Medicaid program because it no longer has enough funds to continue to offer the same services. We regret if any of these changes cause you difficulties. Many of the following changes may not affect you. Please read the entire newsletter carefully and call the Medicaid Resource Center at 1-888-549-0820 if you have any questions.

SERVICES TO BE ELIMINATED

Effective February 1, 2011, the following services will no longer be offered through Medicaid:

- Podiatry services for people 21 and older
- Vision services for people 21 and older
- Dental services for people 21 and older
- Hospice care services for people 21 and older
- Coverage of routine newborn circumcisions

SERVICES TO BE REDUCED

Also effective February 1, 2011, the following services will be reduced in scope:

- One pair diabetic shoes a year instead of two
- Home health visits reduced to 50 visits per year instead 75
- Individuals under 21 years of age can receive a combined total of 75 visits per year for private rehabilitative services (speech and language therapy, occupational therapy or physical therapy)
- Chiropractic services will be reduced to six visits per year instead of eight

CO-PAYMENT ADJUSTMENTS

Beginning April 1, 2011, the Medicaid program will increase the small part of your medical bill that you must pay for some services, called a co-payment. The provider will tell you when you need to make a co-payment. The new co-payment schedule is listed below:

	Old	New
Office Visits	$2.00	$2.30
(Physician, Nurse Practitioner, Licensed Midwife)		
Chiropractor	$1.00	$1.15
Home Health	$2.00	$2.30
Clinic Visits	$2.00	$2.30
Prescription Drugs	$3.00	$3.40
Outpatient Hospital	$3.00	$3.40
Medical Equipment/Supplies	$0-3.00	$.60-3.40

The following Medicaid beneficiaries do not have to make co-payments:

- Children under 19 years of age
- Pregnant women
- Individuals receiving Family Planning services
- Institutionalized individuals
- Individuals receiving emergency services
- Federally recognized Native Americans

For Community Long-Term Care Waiver Beneficiaries Only

Effective April 1, 2011, the following Community Long Term Care services will no longer be offered through Medicaid:

- Chore service
- Appliance service
- Nutritional supplements
- Adult day health care nursing service
- Respite service

The following service reduction is effective April 1, 2011:

- Home-delivered meals will be reduced to 10 per week instead of 14

If you feel this action is taken in error, you may ask for a fair hearing before the South Carolina Department of Health and Human Services. To ask for a fair hearing, send a request in writing within 30 days of the date of this letter.

You can hire an attorney to help you or you can have someone come to the hearing and speak for you. If you request a hearing before the date of action your Medicaid benefits will continue until a ruling is made by the hearing officer. Please note, if the hearing officer does not rule in your favor, you will be required to pay back any Medicaid benefits you received while your case was being reviewed.

EPSDT Notice

Medicaid offers a screening, diagnosis, and treatment program called EPSDT. EPSDT stands for Early Periodic Screening, Diagnosis, and Treatment. It is important for your child to have these regular well-child visits with his/her doctor so that medical problems may be found and treated. If you have a doctor for your child, call and make an appointment for a screening. If you need help finding a doctor, please call your local health department, or check our website at www.scdhhs.gov. If you do not know your local health departments phone number, call the Department of Health and Environmental Control (DHEC) at 1-800-868-0404.

S.C. Healthy Connections Choices

The way you get Medicaid in South Carolina has changed. Medicaid members may now enroll in a health plan.

A health plan is a group of doctors and may also include hospitals and other staff. Your health plan will make sure you can see the right doctors when you need them. All plans provide the same medical services as Medicaid, but they may also offer extra services, like diabetes or asthma management programs.

You may have already received a packet in the mail from South Carolina Healthy Connections Choices. It is very important that you read it. If you don't choose a plan, we may choose a plan for you.

If you go to a doctor you want to continue to see, you can call 1-877-552-4642 or visit www.scchoices.com to find out what plan he or she belongs to. You can call at anytime. Don't wait – enroll with a plan now.

Keep Your Benefits

Medicaid requires each beneficiary to complete a review form at certain times. Some people may need to fill out a form every three months, and others may only need to fill one out every year.

When it is time for your review, we will mail you a form called the Medicaid Review Form. This form will tell you what information you must return to us. We may need to know how much money you earn, what property you own, or if you have childcare expenses. You must answer all the questions on the form and sign it. It is important that you mail this form back to the address listed on the form, and mail it back by the due date. If you fail to return your Medicaid Review Form on time, your Medicaid benefits will end.

If you have questions, please call 1-888-549-0820.

En Espanol

Si necesita esta boletín informativo de Medicaid en español, por favor llame a la oficina de medicaid al 1-888-549-0820. La llamada es gratuita.

SCHIEx Notice

Your health and the care you receive are very important to us. That is why we are participating in a statewide computer system called the South Carolina Health Information Exchange (SCHIEx). This computer system can help the doctors you work with give you better care. SCHIEx is a statewide effort that lets doctors look-up your health facts for treatment purposes over a secure web site. Your health record contains facts like your name and date of birth, and data about medical services and care you have received.

Because your privacy is very important, only approved users such as doctors and medical staff can access SCHIEx. They must have an ID to see information about you. All users must agree to keep your health facts private, and must follow all federal and state privacy laws.

While we hope you will participate in SCHIEx, it is not required. You may choose to stop at any time. Before deciding to stop, please keep in mind that data in SCHIEx can help you and your doctor make better choices about your care.

If you do not want doctors to see your health facts, or have questions, please call the Resource Center at 1-888-549-0820. Or, you may view a demonstration and get more information at www.schiex.org.

Questions?

Call the Resource Center
Monday through Friday 8 a.m - 5 p.m. at
1-888-549-0820
if you have any questions.

South Carolina Healthy Connections
P.O. Box 8206
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