Department of Health & Human Services
Centers for Medicare & Medicaid Services
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CMS
CENTERS for MEDICARE & MEDICAID SERVICES

June 23, 2011

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

Re: South Carolina Title XIX State Plan Amendment, Transmittal #11-005

Dear Mr. Keck:

This letter is being sent as a companion to our approval of South Carolina State Plan Amendment (SPA) 11-005. The SPA was submitted to reduce provider payments by 3 percent for services provided on or after April 4, 2011 by reimbursing providers at 97 percent of the Medicaid rate or Medicaid payment calculated, in accordance with the methodologies in effect on April 1, 2011. During our review of SC 11-005, we noted the following Medicaid Services that will be impacted by this plan amendment: other lab and x-ray; EPSDT; family planning; physician; podiatrist; optometrist; chiropractor; certified registered nurse anesthetist; nurse practitioner; psychologists; licensed midwives; medical social services; home health; clinic; dental; physical and occupational therapy; speech and audiology, pharmaceutical; prosthetic devices and medical supplies, equipment and services; eyeglasses; preventive services; preventive services disease management; rehabilitative services, personal care, nurse midwife, case management; extended pregnancy related services, non-broker provided transportation and Program of All Inclusive Care for the Elderly services.

The Centers for Medicare & Medicaid Services (CMS) did not conduct a review of South Carolina's personal care services program during the corresponding coverage review of 11-005. South Carolina is currently working with CMS through the MSTAT process to bring the State's personal care program into compliance. The lack of a review does not constitute an approval of the State's current personal care program.

Based on that review, it was determined that a number of the methodologies in Attachment 4.19 B and corresponding 3.1-A pages of the State Plan are not consistent with the following Medicaid statutory and regulatory requirements. Therefore, we would like to offer our continuing assistance with your efforts. Attached to this letter are the specific reimbursement and coverage concerns.

Comprehensiveness of the State Plan

Section 1902(a) of the Act requires that States have a State plan for medical assistance that meets certain federal requirements that set out a framework for the State program. Implementing regulations at 42 CFR 430.10 require that the State plan be a comprehensive written statement containing all information necessary for CMS to determine whether the plan can be approved as a basis for Federal Financial Participation (FFP) in the State program.

In addition, section 1902(a)(30)(A) of the Act requires that States have methods and procedures in place to assure that payments to providers are consistent with efficiency, economy, and quality of care. To be comprehensive, payment methodologies should be understandable, clear, and unambiguous. In addition, because the plan is the basis for FFP, it is important that the plan language provide an auditable basis for determining whether payment is appropriate.

1. As you will note in the attachment to this letter, we are requesting the State to make methodology changes when the plan is unclear or does not contain enough information to identify the payment rate. For example, in many areas of the approved State plan South Carolina does not identify the payment rate, nor does it identify a methodology for determining the payment rate. The State indicates that it uses a fee schedule, but does not include the fee schedule itself, nor does it identify how providers and auditors can locate the applicable fee schedule and the period for which the fee schedule is in effect.

   In order to comply with the above mentioned statutes and regulation, the State must amend its approved State plan to include information to comprehensively describe its payment rates for these services. Where payment is made pursuant to a fee schedule, the State should insert language such as the following into each of the reimbursement provisions.

   "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)*."

2. In addition, in reviewing the reimbursement pages we have noted several reimbursement provisions which require reconciliation to actual, incurred Medicaid cost. CMS has approved methodologies that annually reconcile interim payment rates to actual Medicaid cost for States that use CPEs, IGTs, or Medicaid State appropriated funding. However, the State Plan must include detailed language outlining how cost is identified. This information usually includes identification of the direct and indirect cost, the allocation method, and the reconciliation and/or settlement process.

3. Furthermore, in conducting the corresponding coverage page review, we distinguished several coverage provisions which require additional clarification and information. The State Plan must include comprehensive language outlining these services (reference Attachment 2).

In order to comply with the above mentioned statutory and regulatory provisions, the State must amend its approved State plan to include information to comprehensively describe the payment rates and methodologies for those services. The State has 90 days from the date of this letter to address the issues described above. The State may submit SPAs to address the inconsistencies or submit a corrective action plan describing in detail how the State will resolve the issue identified above in a timely manner. Failure to respond will result in the initiation of a formal compliance process.

CMS welcomes the opportunity to work with you and your staff to discuss options for resolving the concerns outlined in the attachment. If you have any questions, please feel free to contact the following members of my staff, Yvette Moore at (404) 562-7327 or Tandra Hodges at (404) 562-7409.

Sincerely,

Davida Kimble

Davida Kimble
Acting Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Attachments

Attachment 1
Reimbursement

Other Laboratory and X-Ray Services *4.19B; Page 2, Section 3*

1. This provision references a payment methodology that is end dated as of June 30, 2009. Based on this language SC is no longer authorized to make payments under this methodology. Please submit a new payment methodology for this service.

Family Planning Services and Supplies *4.19B, Page 2a.2, Section 4.c*

2. This section provides for reimbursement "at an established fee schedule" based on cost. For the Family Planning specific fee schedule as discussed in this section, please add the following language to this section:

   > "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)."

Professional Trauma Fund *4.19B, Page 2b and 2b1*

3. This section implies that the Primary Care Incentive Payments were discontinued effective July, 1, 1998. Please remove this language from the plan pages.

Medical Social Services *4.19B, Page 3.1, Continuation of Section 6d*

4. In order to maintain consistency between the coverage and reimbursement pages, please rename this service to Social Work Services as this is what is currently approved under the other licensed practitioner benefit. There is no benefit in Medicaid known as Medical Social Services.

Clinical Services and Dental Services *4.19B, Page 3a*

5. CMS issued a companion letter on 4/4/11 for SC-11-001 addressing these services. We await the State's response.

Preventive Services *4.19B, Page 6*

6. This 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.

   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.

Case Management Services *4.19B, Sections 6a-6e*

7. In reviewing the case management reimbursement provisions, there were several areas where the State will need to more clearly explain the reimbursement methodology. Summarized below are these concerns:

   a. Monthly rates—Monthly rates provide for a fixed payment regardless of the number of services furnished or the specific cost of those services. It is not economic to pay for days of service when a beneficiary is not actually receiving covered services. In addition, it is not efficient or consistent with quality of care to pay a monthly patient rate because the variability in service level would result in insufficient payment for some patients (who might then be underserved) and excessive payment for other patients. It is CMS's position that these rates are more appropriate as per member per month capitated payments which are governed by contract rules at 42 CFR 438. On a fee-for-service basis, CMS recognizes units of service up to weekly rates.

   b. Payments not to exceed cost—In several of the methodologies, the State includes a payment limit for some providers at cost. Therefore, it is important to include a specific cost methodology in the plan for each provision (e.g. direct, indirect, use of a time study, allocation methodology, interim rate methodology, reconciliation and settlement process). In addition, CMS will review information that supports this process (i.e. cost report/instructions, chart of accounts, materials and supplies, etc.)

   c. Fee schedules—For fee schedule payments that are in units less than a month, the State should include language that comprehensively describe the fee schedule such as the following:

      "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)*."

      Sunset language on page 6e of attachment 4.19-B—The sunset language on this page indicates "As of June 30, 2006, services will no longer be covered and reimbursed." It is not clear which group this language applies to, however, based on this language please delete the applicable methodology from the state plan.

4.19B, Page 6h5, Section c. 1. & 2

8. *4.19B, Page 6h5, Section c. 1. & 2* appears to be in the State plan twice. These pages should be listed in the complete State Plan as approved in SC 08-021's approval.

Attachment 2
Coverage

Targeted Case Management – All Target Groups

CMS recommends that the State of South Carolina revise pages for each target group and resubmit pages that describe each case management services under (19) in the State Plan in accordance with section 42 CFR 441.18.

Please refer to the guidance that was previously provided to the State which outlines all of the requirements for targeted case management that South Carolina may use to be compliant with TCM regulations. We are not requiring States to use the SPA outline for targeted case management services. However, in the past, States reported that the SPA outline was a useful framework for developing State plan amendments and facilitated the review process.

1. The partial moratorium on the Medicaid case management services interim final rule, CMS 2237 IFC, terminated on June 30, 2009, and the remaining provisions (as impacted through the partial rescission final rule (CMS 2237 F)) were effective on July 1, 2009. As a result, 42 CFR 441.18(a)(8) became effective requiring States to submit a separate SPA for each TCM group when the TCM services differ in terms of provider qualifications, services, or methodology under which case management providers would be paid. Please submit a separate SPA for each target group and a corresponding reimbursement page.

2. 42 CFR 441.18(c) allows States the option to provide case management services to individuals transitioning from medical institutions to the community. Please clarify if the SPA would include targeted case management services for the purpose of transitioning individuals from medical institutions to the community. If so, please specify in the plan the number of days (up to 180) during which such services would be provided.
    - Please explain if any participants would reside in institutions for mental diseases or are involuntary residing in public institutions.

3. Please describe the 4 elements of Case Management for each target group as indicated in the Interim Final Rule: 1)Comprehensive assessment and periodic reassessments; 2) Development of a specific care plan; 3) Referral and related activities; and 4) Monitoring and follow-up activities. Define services consistent with 42 CFR 440.169 and specify the frequency of assessments and monitoring.

4. Per 42 CFR 441.18(a)(7), please insert language into the plan that documents how providers will maintain records for individuals receiving case management as follows: (i) the name of the individual; (ii) the dates of the case management services; (iii), the name of the provider agency and the person providing the case management service; (iv) the nature, content, units of the case management services received and whether goals specified in the care plan have been achieved;

    (v) whether the individual has declined services in the care plan; (vi) the need for, and occurrences of, coordination with other case managers; (vii) a timeline for obtaining needed services; and (viii) a timeline for reevaluation of the plan.

5. It is unclear if the targeted case management services are provided in accordance with 42 CFR sections 441.18(a)(2), 42 CFR 441.18(a)(3) and 42 CFR 441.18(a)(6). Please revise the State plan to comply with the regulations.

6. On Page 8z.1 the State plan indicates that "as of June 30, 2006, services will no longer be covered and reimbursed". It is unclear which group this language is referring to. Please clarify which group is no longer covered and reimbursed and remove the group from the State plan.

Foster Children, Juvenile Justice, Adult Protective Services

7. 1902(a)(23) allows for any willing and qualified provider to be able to furnish Medicaid services to eligible individuals. Please clarify if any willing and qualified provider may provide case management services to eligible individuals in these target groups. Additionally, please clarify if all eligible individuals in these target groups are in the custody of the State.

Nurse Practitioner Services

8. On Attachment 3.1A, page 8a, item 23, the State notes that they don't provide pediatric and family nurse practitioner services. This is a mandatory benefit category. If the State doesn't have any of these types of nurse practitioners in their State, then that must be noted in the State plan. When the State says that these services are not provided, it infers that the State is not providing mandatory services, which is not allowable.

Physician Services

9. On Attachment 3.1A, limitation supplement, page 3a, paragraph 1, the State notes that rural health clinic encounters are included in the 12 visit limitation to ambulatory care visits. This is not allowable as limitations to benefits cannot be combined. Rural Health Clinic services are a separate Medicaid benefit category; therefore, any limitation to this service must be placed in the corresponding section and cannot be combined with any other benefit category. Please remove this from the physician services section and provide assurance that these visit limitations are no longer being combined.

10. On Attachment 3.1A, limitation supplement, page 3a, paragraph 4, the State notes that there are restrictions for speech therapy, speech and hearing examinations, physical therapy, occupational therapy, and vision services. Please describe these restrictions - because they may be actual limitations that will need to be included in the State plan.

11. On Attachment 3.1A, limitation supplement, page 3a, under Preventive Care, the State describes what type of preventive services they provide. This is in the incorrect section of the State plan.

    - The 1st paragraph under "Preventive Care" is about well baby care which should be in the EPSDT section of the State plan – item 4b.

- The 2nd paragraph which mentions immunizations for beneficiaries under EPSDT should be in the EPSDT section. The influenza, pneumonia, and hepatitis vaccinations for adults can remain in this section or it can be placed in the preventive section of the State plan – item 13c.

- The 3rd paragraph and the remaining verbiage belongs in the preventive section of the State plan – item 13c.

Preventive Services

12. On Attachment 3.1A, limitation supplement, page 6 and 6a, item 13c, preventive services. The State describes "Preventive Services for Primary Care Enhancement." Please describe what this program actually is and how it operates.

Psychologists Services

13. The State describes psychologist services in item 6d on Attachment 3.1-A Limitation Supplement, page 4a. Please clarify what "other psychological services not related to EPSDT" are, and how they relate to services provided by licensed psychologists under Federal regulations at 42 CFR 440.60. If these services do not relate to the services in 6.d provided by licensed psychologists, please remove.