DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

**Centers for Medicaid, CHIP, and Survey & Certification**

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

JUN 29 2011

RE: State Plan Amendment SC 11-008

Dear Mr. Keck:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 11-008. Effective April8, 2011 this amendment proposes to revise the inpatient hospital and psychiatric residential treatment facilities payment methodologies. Specifically, payment rates for services provided on or after April 8, 2011 will be reduced to ninety seven percent (97%) of the rates in effect on October 1, 2010 except for the largest teaching hospital in the state. This amendment also includes certified public expenditure protocol.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a), 1902(a)(13), 1902(a)(30), 1903(a) and 1923 of the Social Security Act and the implementing Federal regulations at 42 CFR Part 447. We have found that the proposed changes in payment methodology comply with applicable requirements and therefore have approved them with an effective date of April 8, 2011. We are enclosing the CMS-179 and the amended approved plan pages.

If you have any questions, please call Stanley Fields at (502) 223-5332.

Sincerely

/S/

Cindy Mann
Director, CMCS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

**TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL**

**FOR: HEALTH CARE FINANCING ADMINISTRATION**

1. TRANSMITTAL NUMBER: SC 11-008

2. STATE: South Carolina

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
04/08/11

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:

42 CFR Part 447 Subpart C

7. FEDERAL BUDGET IMPACT: FMAP
a. FFY 2011 $(3,971,874)
b. FFY 2012 $(9,303,358)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-A, pages 1, 2, 2a, 4, 13, 15 thru 21, 24, 25, 26, 29 and 33

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Attachment 4.19-A, pages 1, 2, 2a, 4, 13, 15 thru 21, 24, 25, 26, 29 and 33

10. SUBJECT OF AMENDMENT:
Inpatient hospital and RTF payment reductions effective April 8, 2011

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Mr. Keck was designated by the Governor to review and approve all State Plans

12. SIGNATURE OF STATE AGENCY OFFICIAL:
[redacted]

13. TYPED NAME:
Anthony E. Keck

14. TITLE:
Director

15. DATE SUBMITTED:
April 7 , 2011

16. RETURN TO:

South Carolina Department of Health and Human Services
Post Office Box 8206
Columbia, SC 29202-8206

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED:

18. DATE APPROVED:
06-29-11

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
APR - 8 2011

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME: William Lasowski

22. TITLE:
Deputy Director, CMCS

23. REMARKS:

FORM HCFA-179 (07-92)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF SOUTH CAROLINA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - INPATIENT HOSPITAL AND PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY CARE

I. General Provisions

A. Purpose

This plan establishes:

1. a retrospective reimbursement system for qualifying acute care hospitals as defined in the plan, non-state owned governmental long-term care psychiatric hospitals and Department of Mental Health long-term psychiatric hospitals
2. a prospective reimbursement system for all other acute and non-acute care hospitals providing inpatient hospital services and
3. a prospective payment reimbursement system for private psychiatric residential treatment services and a retrospective reimbursement system for state-owned governmental and non-state owned governmental psychiatric residential treatment services in accordance with the Code of Federal Regulations. However, effective for services provided on and after April 8, 2011, the non-state owned governmental psychiatric residential treatment facility's retrospective cost settlement will be limited to ninety-seven percent (97%) of allowable Medicaid costs.

It describes principles to be followed by Title XIX inpatient hospital and psychiatric residential treatment providers and presents the necessary procedures for setting rates, making adjustments, calculating retrospective cost settlements for qualifying acute care hospitals, auditing cost reports and managing the hospital disproportionate share (DSH) program.

B. Objectives

Effective October 1, 1997, the Balanced Budget Act (BBA) of 1997 repeals the OBRA 1981 requirement. In its place, the BBA of 1997 provides for a public process for determination of hospital payment rates. This public process will take place for all changes in payment for inpatient hospital and disproportionate share.

Inpatient hospital reimbursement shall be made in accordance with the upper payment limit requirements of Section 447.272.

C. Overview of Reimbursement Principles

1. The South Carolina Medicaid Program will reimburse qualified providers for inpatient institutional services using one or more of the following methods.

a. Prospective payment rates will be reimbursed to contracting

out-of-state acute care hospitals with SC Medicaid fee for service inpatient claim utilization of less than 200 claims during its cost reporting period.

b. Reimbursement for out of state border general acute care hospitals with S.C. Medicaid fee for service inpatient claims utilization of at least 200 claims and all S.C. non-general acute care hospitals (i.e. long term acute care hospitals, free standing short-term psychiatric hospitals, and free standing long-term psychiatric hospitals) will be based on a prospective payment system that will be further limited to no more than one hundred percent of the hospital's allowable SC Medicaid inpatient cost. Effective for discharges occurring on and after April 8, 2011, the annual analysis will be performed to ensure that Medicaid inpatient reimbursement does not exceed ninety-seven percent (97%) of allowable SC Medicaid inpatient costs.

c. Retrospective inpatient cost settlements will be determined for all contracting SC general acute care hospitals, all non-state owned governmental long-term care psychiatric hospitals, all contracting SC psychiatric hospitals owned by the SC Department of Mental Health, and qualifying hospitals that employ a burn intensive care unit. However, effective for discharges occurring on and after April 8, 2011, retrospective cost settlements will be limited to ninety-seven percent (97%) of allowable SC Medicaid inpatient costs for all SC general acute care hospitals except for the largest teaching hospital in the state. The largest teaching hospital in the state will continue to receive one hundred percent of its allowable Medicaid inpatient costs via a retrospective cost settlement. Additionally, effective for discharges occurring on and after April 8, 2011, the retrospective cost settlement amount for qualifying hospitals with a burn intensive care unit will be limited to ninety-seven percent (97%) of allowable SC Medicaid inpatient costs.

2. Medicaid reimbursement to a hospital shall be payment in full. Hospitals may not separately bill the patient or the Medicaid program for medical services rendered during an inpatient stay, except as provided in Section III of this plan and/or coinsurance. Hospitals may submit a claim for payment only upon final discharge of the patient, with the exception of long-term care psychiatric hospital claims and psychiatric residential treatment facility claims.

3. Payment for all hospitals (except freestanding long-term care psychiatric hospitals) will be made based on a hybrid payment system which compensates hospitals either an amount per discharge (per case) for a diagnosis related group or a per diem rate.

4. For discharges paid by the per case method under the hybrid payment system, South Carolina specific relative weights and rates will be utilized. Effective October 1, 2007, the Medicare

DRG classification system that will be used will be DRG grouper version 24. The relative weights will be established based on a comparison of charges for each DRG category to charges for all categories. South Carolina's historical Medicaid claims database incurred from July 1, 2005 through June 30, 2006 will be used to establish the DRG relative weights.

5. For discharges paid by the per diem method, statewide per diem rates are established for the following categories of hospitals: teaching hospitals with an intern/resident program, teaching hospitals without an intern/resident program, and non-teaching hospitals. Effective October 1, 2008, facilities will receive the appropriate per diem rate times the number of days of stay, (subject to the limits defined in this plan) multiplied by the hospital specific inpatient per diem multiplier.

Effective for discharges occurring on and after April 8, 2011, the retrospective cost settlement amount for qualifying hospitals with a burn intensive care unit will be limited to ninety-seven percent (97%) of allowable SC Medicaid inpatient costs.

II. Definitions Applicable to Inpatient Hospital and Residential Treatment Facility Reimbursement

The following definitions will help in understanding the payment rates set for inpatient hospital and residential treatment facility services:

1. Administrative Days - The days of service provided to recipients who no longer require acute hospital care, but are in need of nursing home placement that is not available at the time. The patient must meet either intermediate or skilled level of care criteria.

2. Arithmetic Mean (average) - The product of dividing a sum by the number of its observations.

3. Base Year - The fiscal year used for calculation of payment rates. For the hybrid payment system rates effective on and after April 8, 2011, the base year shall be each facility's 2006 fiscal year. For the freestanding long-term psychiatric hospital rates, the base year shall be each facility's 1990 fiscal year.

4. Burn Intensive Care Unit Cost Settlement Criteria - In order to qualify for this cost settlement a hospital must satisfy all of the following criteria. A hospital must:

   - Be located in South Carolina or within 25 miles of the South Carolina border;
   - Have a current contract with the South Carolina Medicaid Program; and
   - Have at least 25 beds in its burn intensive care unit.

5. Capital - Cost associated with the capital costs of the facility. Capital costs include, but are not limited to, depreciation, interest, property taxes, property insurance, and directly assigned departmental capital lease costs. In no case shall the capital amount include amounts reflecting revaluation of assets due to change of ownership or leasing arrangement subsequent to September 1, 1984.

6. Case-Mix Index - A relative measure of resource utilization at a hospital.

7. Cost - Total SC Medicaid allowable costs of inpatient services, unless otherwise specified.

8. CRNA - Certified Registered Nurse Anesthetist.

9. Diagnosis Related Groups (DRGs) - A patient classification that reflects clinically cohesive groupings of patients who consume similar amounts of hospital resources.

10. Direct Medical Education Cost - Those direct costs associated with an approved intern and resident or nursing school teaching program as defined in the Medicare Provider Reimbursement Manual, publication HIM-15.

expenditures component of the Consumer Price Index and represents the current unadjusted twelve months experience ending June 30, 2007. For the per discharge rate setting, different inflation factors were determined based upon the hospital's fiscal year end(e.g. FYE 9/30/06 trend rate = .1248736, FYE 6/30/06 trend rate = .1359612, etc.). For the statewide per diem rate setting, only one inflation factor was determined and used for rate setting purposes. The trend factor used was .1248736. For per discharge and statewide per diem rates effective April 8, 2011, no additional trend was applied, as trend was incorporated into the calibration factor.

2. Free-Standing Long-Term Psychiatric Hospitals

For the freestanding long-term psychiatric hospital rates, the annual trend rates used to trend the FY 1990 SC Medicaid inpatient cost to the current rate period are as follows:

| Period | TEFRA Non-PPS Rate of Increase |
|---|---|
| 10/1/89 - 9/30/90 | 5.2% |
| 10/1/90 - 9/30/91 | 4.4% |
| 10/1/91 - 9/30/92 | 4.7% |
| 10/1/92 - 9/30/93 | 4.7% |
| 10/1/93 - 9/30/94 | 4.9% |

Because these rates of increase are based on the Federal fiscal year, they will be adjusted to coincide with the State fiscal year.

The following calculations are performed to adjust FY 1990 costs to the reimbursement period.

a. To compensate for varying fiscal year ends, each facility's 1990 fiscal year cost will be adjusted to reflect dollars as of a single point in time (12/31/90). For example, a facility with a 6/30 fiscal year end will have an additional inflation factor applied to its costs. This inflation factor will be calculated by dividing the number of days between 6/30 and 12/31 (184) by 365. The resulting percent will be multiplied by the applicable TEFRA Non-PPS factor. This factor will be calculated by adding 1.00 to the sum of the values derived from multiplying 5.2% times 9/12 (9 months of FY 1990) and multiplying 4.4% times 3/12 (3 months of FY 1991).

b. A factor will be calculated to inflate costs from July 1, 1990 (midpoint of December 31, 1990 fiscal year) to January 1, 1994 (midpoint of June 30, 1994 fiscal year). Adding 1.00 to a through e below and then multiplying these numbers together calculate this factor.

i. 3/12 x .052
(three months of the FY 1990 rate of increase)

ii. 12/12 x .044
(twelve months of the FY 1991 rate of increase)

E. Medicaid Case-Mix Index

A case-mix index, which is a relative measure of a hospital's resource use, will be used to adjust the per discharge cost amounts to the statewide average case-mix. For each hospital the per discharge case-mix index will be computed by multiplying the number of incurred SC Medicaid inpatient claims during its FYE 2006 cost reporting period in each per case DRG by the DRG relative weight, summing these amounts and dividing by the sum of the total per case discharges. DRG grouper version 24 and the October 1, 2007 relative weights were used in the calculation of the case mix index for each hospital.

F. Outlier Set-Aside Factor

Cases were statistically tested to determine the amount of expense that would be set aside to be distributed as outlier payments. Cases in which the charge exceeded the arithmetic charge per case plus two times the standard deviation were flagged as an outlier for set aside purposes. The amount of charges that exceed the trim point was also calculated. This sum was divided by the total charges in the pricing dataset to determine the adjustment factor that would be used to reduce the individual hospital base rates for re-distribution as outlier payments. Only claims for cases to be paid by the per discharge method will be included in this analysis. The outlier set-aside factor for the hybrid payment system effective on and after October 1, 2008 will be 4.07%. The DHHS may adjust future set-asides to reflect more current information.

G. Psychiatric Residential Treatment Facility Costs

Psychiatric residential treatment facility per diem reimbursement rates, effective for dates of service beginning on or after 09/01/98, shall be calculated using each facility's desk-reviewed cost report data reflecting allowable costs in accordance with CMS Publication 15-1 and the all-inclusive rate definition. Cost will come from each facility's 1997 CMS-2552(Medicare/Medicaid Cost Report), with exception when applicable (e.g. professional service costs and subsequent period costs). If applicable, add-ons will be calculated and applied to the RTF rate for services required by the RTF program subsequent to the 1997 cost reporting period. These add-ons will be calculated using future cost report and/or budgeted cost and statistical data.

V. Reimbursement Rates

A. Inpatient Hospital

The computation of the hybrid payment system rates will require three distinct methods - one for computation of the hospital specific per discharge rates, a second for computation of the statewide per diem rates, and a third for computation of the statewide per diem rate for freestanding long-term care psychiatric facilities.

1. Hospital Specific Per Discharge Rates

The following methodology is employed in the computation of the hospital specific per discharge rates effective October 1, 2008:

a. SC Medicaid allowable inpatient costs as described in Section IV for each acute care hospital are broken down into the following cost components:

i. base inpatient costs (total-DME-IME-capital)
ii. direct medical education costs (including capital)
iii. indirect medical education costs
iv. capital costs (less DME capital)

b. Each cost component identified in 1 a. above is divided by the number of inpatient claims incurred by the hospital during its FY 2006 cost reporting period to arrive at a cost per claim for each cost component. Inpatient claims data is derived from the SCDHHS MARS paid claims summary report.

c. Each cost component identified in 1 b. above (except for capital and DME capital) is trended by the inflation factor described under Section IV C 1. The four trended cost components are then summed to determine the total allowable SC Medicaid inpatient costs on a per claim basis that will be used for per discharge rate setting for each acute care hospital.

d. The total allowable SC Medicaid trended inpatient costs on a per claim basis as identified in 1 c above for each acute care hospital is reduced by the outlier set aside amount of 4.07%, and case mix adjusted to establish an ``adjusted per discharge rate'' for each acute care hospital.

e. The ``adjusted per discharge rate'' identified in 1.d. above is multiplied by a calibration factor to determine each acute care hospital's ``actual per discharge rate'' effective October 1, 2010. Effective for discharges occurring on and after April 8, 2011, the ``actual per discharge rate'' for each acute care hospital will represent ninety-seven percent (97%) of the October 1, 2010 ``actual per discharge rate'' except for the largest teaching hospital in the state. The largest teaching hospital in the state will continue to receive one hundred percent (100%) of its October 1, 2010 ``actual per discharge rate''.The purpose of the inpatient base rate calibration process is to normalize each hospital's per discharge base rate for differences between its mix of cases and the statewide Medicaid mix of cases. Some of the more relevant differences include:

1) The starting individual base rate for each hospital is calculated based upon its individual cost to charge ratio times the facility's allowed charge per case. Because portions of the reimbursement methodology are based upon the statewide cost to charge ratio, to the extent that a facility varies (either positively or negatively) from the statewide cost to charge ratio, the financial impact of the starting base rate will be influenced.

2) To the extent that a facility varies from other statewide measures used in the methodology (i.e. DRG relative weights, average length of stay, mix of inlier and outlier cases, reimbursement methodology, etc), the financial impact of the overall system to the facility will be influenced.

Effective October 1, 2010, to calibrate the starting reimbursement rates for the differences noted above, a two-step model is employed. In the first iteration of the model, the starting rates are simulated using the statewide measures, case rates, per diem rates, and reimbursement rules. Once that step is completed, the resulting model payments are compared to an estimated cost target developed by the Medicaid Agency for each eligible hospital that represents 100% of allowable Medicaid inpatient hospital costs effective October 1, 2010. The amount of difference (either positive or negative) is compared to the payments made for all discharges. From this relationship, a factor is developed that is used to adjust the hospital's base rate (per diem cases are described under section 2.g.) to move the facility closer to the target reimbursement. For example, if a hospital is $1,000,000 short of the targeted reimbursement amount and that facility had $10,000,000 in payments, a factor of 1.10 would be applied to its base rate. Conversely, if that same hospital had model payments of $1,000,000 in excess of its target, an adjustment of .90 would be applied to the facility's base rate.

f. In order to allocate the ``actual per discharge rate'' of each hospital into the four cost components (i.e. base, DME, IME, and capital), each trended cost component identified in 1 c above is divided by the sum of the four trended cost components to determine each component's percentage of the total trended Medicaid inpatient costs on a per claim basis. This percentage is then applied against the ``actual per discharge rate'' determined in 1 e above to determine each component's portion of the ``actual per discharge rate''.

g. A statewide per discharge rate will be established for teaching hospitals with an intern/resident program, teaching hospitals without an intern/resident program, and non-teaching hospitals. Hospitals that will receive the appropriate statewide per discharge rate will include long term acute care hospitals, freestanding short term psych hospitals, out of state contracting acute care hospitals with SC Medicaid fee for service inpatient claims utilization of less than 200 claims, new acute care hospitals that come on line after 2006, and contracting acute care hospitals with high cost/low SC Medicaid inpatient claim utilization. The October 1, 2010 statewide per discharge rate will be held to the October 1, 2008 payment rate. Effective for discharges occurring on and after April 8, 2011, the statewide per discharge rate will represent ninety-seven percent (97%) of the October 1, 2010 statewide per discharge rate.

h. The rate determined above is multiplied by the relative weight for that DRG to calculate the reimbursement for a per case DRG claim. Outlier amounts will be added if applicable.

2. Statewide Per Diem Rates

Data from claims incurred during the period October 1, 2005 through September 30, 2006 were used to calculate the per diem rates. The following steps are involved in the computation of the statewide per diem rates effective October 1, 2008:

a. Calculate the total charges associated with each per diem DRG.

b. Calculate the total days of hospitalization for each per diem DRG.

c. Divide the total charges for each per diem DRG by the total number of days of hospitalization for each per diem DRG. The average charge per day is multiplied by the statewide cost-to-charge ratio of .368735 to calculate the average cost per day for each per diem DRG. The statewide cost-to-charge ratio is determined using the HFY 2006 hospital cost reports.

d. Once the charge has been converted to a statewide cost, multiply the cost by the appropriate trend factor as referred to in Section IV C 1 of the plan. For DRGs with no activity, per diem rates were set at the statewide average.

e. In order to allocate each of the statewide per diem DRG rates into the four cost components (i.e. base, DME, IME, and capital), each trended cost component identified in Section V A I c of the plan is divided by the sum of the four trended cost components to determine each component's percentage of the total trended Medicaid inpatient costs in the aggregate. This aggregate percentage per cost component is then applied against each statewide per diem DRG rate to determine each component's portion. The aggregate percentage per cost component used for the October 1, 2008 statewide per diem rates are as follows:(1) Base = 81.01%; (2) DME = 4.34%; (3) IME = 7.30%; (4) Capital = 7.35%. Once the analysis was completed, separate statewide per diem rates were established for teaching hospitals with an intern/resident program, teaching hospitals without an intern/resident program, and non-teaching hospitals.

f. All acute care hospitals, long term acute care hospitals, and freestanding short term psychiatric hospitals will be reimbursed the applicable set of statewide per diem rates. The October 1, 2010 statewide per diem rates will be held to the October 1, 2008 statewide per diem payment rates.

g. Effective October 1, 2010, in order to convert the statewide inpatient per diem rate payments into hospital specific payments, a hospital specific inpatient per diem multiplier will be developed for each hospital. The inpatient per diem multiplier will convert the calculated statewide per diem claims payment to a hospital specific payment that will be limited to no more than 100% of projected inpatient costs effective October 1, 2010. Hospitals that receive a hospital specific inpatient per diem multiplier will

be those eligible to receive retrospective cost settlements and those contracting out of state border hospitals that have SC Medicaid fee for service claims utilization of at least 200 claims. Effective for discharges occurring on and after April 8, 2011, the hospital specific inpatient per diem multiplier will be reduced to reflect ninety-seven percent (97%) of the October 1, 2010 hospital specific inpatient per diem multiplier except for the largest teaching hospital in the state. The largest teaching hospital in the state will continue to receive one hundred percent (100%) of its October 1, 2010 hospital specific inpatient per diem multiplier. All other contracting hospitals will receive an inpatient per diem multiplier of 1.00. Effective for discharges occurring on and after April 8, 2011, all other contracting hospitals will receive an inpatient per multiplier of .97. The inpatient multiplier will be applied after the inpatient per diem payment has been calculated prior to any reduction for third party liability or coinsurance. The hospital specific per diem multiplier and the hospital specific per discharge rate calibration factor are one in the same and the methodology employed by the Medicaid Agency to calculate these factors can be found under section V A 1 e.

Calibration of per diem rates is achieved using a similar methodology. Using the results of simulation model, the same calibration factor developed for case rates is applied to the applicable per diem rates for each DRG paid under that methodology. For example, if the per diem rate for a given DRG is $500.00 prior to TPL and a calibration adjustment of 1.10 was developed in the simulation iteration, a per diem payment of $550.00 prior to TPL would be allowed. Similarly, a calibration factor of .90 would result in a per diem payment of $450.00 prior to TPL.

3. Per Diem Prospective Payment Rate - Long-Term Psychiatric Facilities

Only freestanding long-term care psychiatric facilities are included in this computation.

a. Adjusted Medicaid inpatient room and board costs are summed across all participating freestanding long-term care psychiatric facilities. The number of days of care is summed across these facilities and the result is divided into the total adjusted costs to yield the statewide average per diem.

b. Hospital specific factors are added to the base rate, as was the case in Section V A. Medicaid days for freestanding long-term care psychiatric facilities are substituted in each computation for discharges. For freestanding long-term care psychiatric facilities providing ancillary services, an ancillary add-on is added to the base rate. The ancillary add-on is calculated in the same manner as the capital, DME and IME add-ons.

c. To determine the amount of reimbursement for a particular claim, the number of certified days of stay is multiplied by the per diem rate for long-term care psychiatric services. No outlier payments will be made for reimbursement to long-term care psychiatric facilities. Effective for services provided on and after April 8, 2011, private and non-profit long-term care psychiatric facilities will receive ninety-seven percent (97%) of its October 1, 2010 rate. Governmental long-term care psychiatric hospitals will not be impacted by this change.

B. Psychiatric Residential Treatment Facility

A per diem rate will be calculated for each South Carolina contracting psychiatric RTF. The rate will be calculated using allowable 1997 base year cost and statistical data as reported on the CMS 2552 cost report trended forward. The rate will cover all costs included in the ``all-inclusive'' rate definition. An occupancy adjustment will be applied if the base year occupancy rate is less than the statewide average occupancy rate. If applicable, add-ons may be applied to the RTF rate for services required by the RTF program subsequent to the 1997 cost reporting period. State government owned and operated facilities, non-state government owned and operated facilities and new facilities will receive special consideration as specified below.

Each facility's occupancy rate will be calculated. If a facility's occupancy rate is less than the statewide average RTF occupancy rate, the routine cost and physician cost (if separately identified) will be adjusted to reflect RTF days at the statewide average occupancy level. The ancillary cost centers (if separately identified) will not be subject to an occupancy adjustment and thus will be subject to the RTFs' actual occupancy rate. No occupancy adjustment will be made for state government owned and operated facilities and non-state government owned and operated facilities.

The 1997 base year psychiatric RTF costs will be inflated using the CMS Market Basket Indices. The base year cost will be inflated through 12/31 of the base year and then the midpoint-to-midpoint inflation method will be used to inflate the rates from the base year to the rate period. If applicable, add-ons will be inflated forward. The midpoint-to-midpoint inflation rates are as follows:

| | |
|---|---|
| FY 1999-00 | 6.37% |
| FY 2000-01 | 11.43% |
| FY 2001-07 | 0.00% |

Effective September 1, 2008, the psychiatric RTF rates will be increased by 7.12%. Effective for services provided on and after April 8, 2011, all non-state owned governmental and private psychiatric RTF rates will represent ninety seven percent (97%) of the October 1, 2010 psychiatric RTF rate.

1. Facility Rate (excluding state government owned and operated, non-state government owned and operated and new facilities).

   For clarification purposes, the per diem reimbursement rate will be calculated in two steps and then summed. The per diem component relating to routine and physician costs (if separately identified) will be calculated by dividing the allowable base year cost by the greater of actual bed days or the occupancy ajusted bed days. The per diem component relating to ancillary costs (if separately identified) will be calculated by dividing the allowable base year cost by the facility's actual bed days. Inflation will be applied to the sum of the two components using the mid-year method. If applicable, add-ons may be applied to the RTF rate for services required by the RTF program subsequent to

the 1997 cost reporting period. These add-ons will be subject to an occupancy adjustment, if applicable, and will be inflated from the period the cost was incurred.

2. State Government Owned and Operated Facility Rate

The per diem reimbursement rate will be calculated by dividing total allowable cost by actual bed days. No occupancy adjustment will be made.

3. Non-State Government Owned and Operated Facility Rate

The per diem reimbursement rate will be calculated by dividing total allowable cost by actual bed days. No occupancy adjustment will be made.

4. New Facility Rate

RTFs enrolled in the SCDHHS Medicaid program subsequent to the 1997 base year will be reimbursed the statewide average RTF rate.

VI. Special Payment Provisions

A. Payment for Outlier Cases - Per Discharge DRG Cases Only

1. Payments in addition to the base DRG reimbursement are available to a facility for covered inpatient services provided to a Medicaid recipient if the following conditions are met:

a. The recipient's covered length of stay exceeds the day outlier threshold for the applicable DRG. The day outlier threshold is three standard deviations above the statewide geometric average length of stay.

b. The hospital's adjusted cost for a claim exceeds $30,000 and the cost outlier threshold. The hospital's adjusted cost is derived by applying the statewide cost-to-charge ratio to the hospital's allowable claim charges. The threshold is calculated by computing two standard deviations above the statewide geometric mean charge, multiplied by the statewide cost-to-charge ratio. The statewide cost to charge ratio effective for discharges occurring on and after April 8, 2011 is .3452.

c. If a claim meets the conditions of 1a and 1b above it will be reimbursed the greater of the two outlier amounts.

2. Additional payments for cases meeting conditions described in 1a above (day outliers) shall be made as follows:

a. If the hospital discharge includes covered days of care beyond the day outlier threshold for the applicable DRG, an additional payment will be made to the provider for those days. A special request by the hospital is not required in order to initiate this payment.

by multiplying the applicable DRG relative weight by the hospital discharge rate and dividing by twice the average length of stay for the DRG. However, when a patient is admitted and discharged, and subsequently readmitted on the same day, the hospital will be paid only one per discharge or per diem payment as appropriate.

F. Payment for Swing Bed Days

Acute care facilities will be reimbursed for qualifying skilled and intermediate care Medicaid patients in accordance with the daily rate schedule shown below.

| | |
|---|---|
| October 1, 2003 - September 30, 2004 | 116.13 |
| October 1, 2004 - September 30, 2005 | 121.92 |
| October 1, 2005 - September 30, 2006 | 129.16 |
| October 1, 2006 - September 30, 2007 | 136.24 |
| October 1, 2007 - September 30, 2008 | 141.52 |
| October 1, 2008 - September 30, 2009 | 146.98 |
| October 1, 2009 - September 30, 2010 | 153.57 |
| October 1, 2010 - April 7, 2011 | 154.67 |
| April 8, 2011 - | 150.03 |

This rate calculation is described in the Nursing Home State Plan Attachment 4.19-D.

G. Payment for Administrative Days

Acute care facilities will be reimbursed for Medicaid eligible skilled or intermediate patients who no longer require acute care and are waiting for nursing home placement. Administrative days must follow an acute inpatient hospital stay and will be covered in any hospital as long as a nursing home bed is not available. Reimbursement for administrative days is described below.

1. Each administrative day will be paid in accordance with the rate schedule shown below. This daily rate will be considered payment in full. There will be no cost settlement. This rate is a combination of the swing bed rate, as defined above, plus the trended Alternative Reimbursement Method (ARM) rate for pharmaceutical services.

| | |
|---|---|
| October 1, 2003 - September 30, 2004 | 123.57 (ARM 7.44) |
| October 1, 2004 - September 30, 2005 | 129.75 (ARM 7.83) |
| October 1, 2005 - September 30, 2006 | 136.99 (ARM 7.83) |
| October 1, 2006 - September 30, 2007 | 144.07 (ARM 7.83) |
| October 1, 2007 - September 30, 2008 | 149.71 (ARM 8.19) |
| October 1, 2008 - September 30, 2009 | 155.56 (ARM 8.58) |
| October 1, 2009 - September 30, 2010 | 162.55 (ARM 8.98) |
| October 1, 2010 - April 7, 2011 | 163.83 (ARM 9.16) |
| April 8, 2011 - | 158.92 (ARM 8.89) |

2. Patients who require more intensive technical services (i.e. patients who have extreme medical conditions which require total dependence on a life support system) will be reimbursed using rates from the following schedule.

| | |
|---|---|
| October 1, 2003 - September 30, 2004 | 188.00 |
| October 1, 2004 - September 30, 2005 | 197.00 |
| October 1, 2005 - September 30, 2006 | 206.00 |
| October 1, 2006 - September 30, 2007 | 215.00 |
| October 1, 2007 - November 30, 2008 | 225.00 |
| December 1, 2008 - April 7, 2011 | 364.00 |
| April 8, 2011. - | 353.08 |

This rate calculation is described in the Nursing Home State Plan Attachment 4.19-D.

This per diem rate will represent payment in full and will not be cost settled.

H. Payment for One-Day Stay

Reimbursement for one-day stays that group to per discharge DRGs (except deaths, false labor, normal deliveries (DRG 373) and normal newborns (DRG 391)) will be reimbursed a DRG per diem. A DRG per diem is equal to reimbursement for applicable DRG divided by the average length of stay for that DRG.

I. New Facilities/New Medicaid Providers

Payment rates for facilities that were not in operation or not contracting with the SC Medicaid Program during the base year will be determined as follows:

a. For hospitals under the hybrid payment system, the per discharge payment rate will be set at the applicable statewide average per discharge rate (i.e. teaching with intern/resident program. teaching without intern/resident program, and non-teaching). New facilities will receive the applicable statewide per diem rates as described in Section V A 2.

b. For freestanding long-term care psychiatric facilities, payment will be at the statewide average per diem for long term care psychiatric facilities plus projected capital and medical education costs as applicable.

c. For Residential Treatment Facilities, payments will be based on a statewide average of all the RTF rates.

J. Retrospective Hospital Cost Settlements

Effective for services provided on or after October 1, 2007, the following types of hospitals will receive retrospective Medicaid inpatient cost settlements. In calculating these settlements, allowable cost and payments will be calculated in accordance with the methodology described in Section VIII.

- 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, will represent one hundred percent (100%) of each hospital's allowable SC Medicaid inpatient costs. However, effective for discharges occurring on and after April 8, 2011, retrospective cost settlements will be limited to ninety-seven percent (97%) of allowable SC Medicaid inpatient costs for all SC general acute care hospitals except for the largest teaching hospital in the state. The largest teaching hospital in the state will continue to receive one hundred percent (100%) of its allowable Medicaid inpatient costs via a retrospective cost settlement.

- All SC psychiatric hospitals owned by the SC Department of Mental Health 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, will represent one hundred percent (100%) of each hospital's allowable SC Medicaid inpatient costs.

- All qualifying hospitals that employ a burn intensive care unit that contract with the SC Medicaid Program will receive retrospective cost settlements that, when added to fee for service and non fee for service (i.e. adjustment) payments, will represent one hundred percent (100%) of each hospital's allowable SC Medicaid inpatient costs. However, effective for discharges occurring on and after April 8, 2011, the retrospective cost settlement amount for qualifying hospitals with a burn intensive care unit will be limited to ninety-seven percent (97%) of allowable SC Medicaid inpatient costs.

- Effective October 1, 2010, all non-state owned governmental long-term care psychiatric hospitals will receive retrospective cost settlements that, when added to fee for service and non fee for service (i.e. adjustment) payments, will represent one hundred percent (100%) of each hospital's allowable SC Medicaid inpatient costs.

Effective October 1, 2010, contracting out of state border hospitals with SC Medicaid fee for service inpatient claims utilization of at least 200 claims, contracting SC long term acute care hospitals, and contracting SC short term and long term freestanding psychiatric hospitals (excluding SCDMH psychiatric hospitals and non-state owned governmental long-term care psychiatric hospitals) will not qualify for retrospective cost settlements. However, an annual analysis will be performed each cost reporting year to ensure that Medicaid reimbursement under the hybrid payment system does not exceed allowable Medicaid inpatient costs. Effective for discharges occurring on and after April 8, 2011, the annual analysis will be performed to ensure that Medicaid inpatient reimbursement does not exceed ninety-seven percent (97%) of allowable SC Medicaid inpatient costs.

K. Graduate Medical Education Payments for Medicaid MCO Members

For clarification purposes, the SCDHHS will pay teaching hospitals for SC Medicaid graduate medical education (GME) cost associated with SC Medicaid MCO members. The managed care GME payment will be calculated the same as the medical education payment calculated by the fee-for-service program. It will be based on quarterly inpatient claim reports submitted by the MCO and the direct and/or indirect medical education add-on amounts that are paid to each hospital through the fee-for-service program. Payments will be made to the hospitals on a quarterly basis or less frequently depending on claims volume and the submission of the required data on the claim reports.

L. Co-Payment

Effective March 31, 2004, a standard co-payment amount of $25 per admission will be charged when a co-payment is applicable. The co-payment charged is in accordance with 42 CFR 447.53, 447.54(c) and 447.55. The inpatient cost settlement will include uncollected Medicaid co-payment amounts in accordance with 42 CFR 447.57.

M. Payment for Out of State Transplant Services

Payment for transplant services provided to South Carolina Medicaid recipients by out of state hospitals (i.e. other than the border hospitals of North Carolina and Georgia) will be based upon a negotiated price reached between the out of state provider and the Medicaid Agency. The negotiated price will include both the professional and the hospital component. Transplant services provided to Medicaid recipients in South Carolina DSH hospitals will be reimbursed in accordance with the payment methodology outlined in Attachment 4.19-A and 4.19-B (i.e. South Carolina general hospitals will be reimbursed allowable inpatient and outpatient costs in accordance with provisions of the plan while the physician professional services will be reimbursed via the physician fee schedule).

VIII. Retrospective Hospital Cost Settlement Methodology:

The following methodology describes the inpatient hospital cost settlement process for qualifying hospitals.

A. A cost-to-charge ratio will be calculated for Medicaid inpatient claims. This ratio will be calculated using cost from worksheet B part I, charges from worksheet C, Medicaid and total days from worksheet S-3 and Medicaid settlement data from worksheets D part V and E-3. For each routine cost center, a per diem cost will be determined by dividing the allowable cost as reported on worksheet B part I (after removing swing bed cost and reclassifying observation cost) by total days as reported on worksheet S-3. This per diem will then be multiplied by Medicaid days as reported on worksheet S-3 in order to determine Medicaid routine cost. For ancillary cost centers, a cost-to-charge ratio will be calculated by dividing cost as reported on worksheet B part I by total charges from worksheet C. Medicaid cost for each ancillary cost center will be determined by multiplying this ratio by Medicaid charges as reported on worksheet D part V. The cost-to-charge ratio will be determined by dividing the sum of the calculated Medicaid routine and ancillary cost by the sum of the Medicaid charges as reported on worksheet E-3 (routine) and D-4 (ancillary). Charges not covered by the hospital payment system, such as CRNA and ambulance, must be excluded from this calculation.

B. Total allowable Medicaid cost will be determined at the time of cost settlement by multiplying the cost-to-charge ratio as calculated in A above, by Medicaid adjusted charges. Medicaid adjusted charges will be determined by multiplying covered Medicaid billed charges by the ratio of covered to billed days. (This will remove charges for patients that are not covered for their entire stay). Charges are also adjusted for non Mars Report adjustments such as claim refunds, third party recoveries, etc. This adjustment is calculated by multiplying the ratio of Mars Report covered charges to Mars Report covered payments by the sum of the non Mars Report adjustment amounts. This amount is subtracted (debit) or added (credit) as appropriate.

C. The interim retrospective cost settlement amount will be determined by subtracting payments received from the allowable cost determined above. The payment amount includes Mars report payments and non Mars Report adjustments that were processed during the cost reporting/settlement period. Examples of these adjustments are small hospital access payments, refunds associated with third party payments, interim cost settlement payments, etc. However, effective for discharges occurring on and after April 8, 2011, retrospective cost settlements will be limited to ninety-seven percent (97%) of allowable SC Medicaid inpatient costs for all SC general acute care hospitals except for the largest teaching hospital in the state. The largest teaching hospital in the state will continue to receive one hundred percent of its allowable Medicaid inpatient costs via a retrospective cost settlement. Additionally, effective for discharges occurring on and after April 8, 2011, the retrospective cost settlement amount for qualifying hospitals with a burn intensive care unit will be limited to ninety-seven percent (97%) of allowable SC Medicaid inpatient costs.

Interim estimated cost settlements will only be allowed in extraordinary circumstances. It will be the responsibility of the provider to request and document the need for the cost settlement which could include the submission of one, or a combination of, the following documentation:

1. a more current annual or a less than full year Medicare/Medicaid

cost report;

d. Psychiatric Residential Treatment Facility (RTF) Cost Reports.

i. All psychiatric RTF cost reports will be desk reviewed. This information may be used for future rate updates.

ii. There will be a retrospective cost settlement for state government owned and operated psychiatric RTFs and non-state government owned and operated psychiatric RTFs. These will be settled at 100% of allowable cost. However, effective for services provided on and after April 8, 2011, the non-state owned governmental psychiatric residential treatment facility's retrospective cost settlement will be limited to ninety-seven percent (97%) of allowable Medicaid costs.

iii. There will be no retrospective cost adjustment for RTFs that are paid the statewide average rate.

e. Certified Public Expenditures incurred in providing services to Medicaid and individuals with no source of third party insurance.

The South Carolina Medicaid Agency uses the **CMS Form 2552-96** cost report for its Medicaid Program and all state owned/operated governmental psychiatric hospitals operated by the South Carolina Department of Mental Health (SCDMH) must submit this report each year. The Agency will utilize worksheet Series S, B, C, and D-4 to determine the cost of inpatient hospital services (no outpatient hospital services provided by SCDMH hospitals) provided to Medicaid eligibles and individuals with no source of third party insurance to be certified as public expenditures (CPE) from the **CMS Form 2552-96.** This cost report will also be used to determine the cost of Psychiatric Residential Treatment Facility (PRTF) services provided by SCDMH. The Agency will use the procedures outlined below:

Cost of Medicaid

I. Interim Reconciliation of Interim Medicaid Inpatient Hospital Payments:

Upon receipt of the SCDMH hospitals' fiscal year end June 30 cost report, each hospital's interim Medicaid fee for service rate payments and any supplemental payments that may had been made which applied to services provided during the cost reporting period will be reconciled to its CMS Form 2552-96 cost report as filed to the Medicare Fiscal Intermediary (FI) and Medicaid Agency for the respective cost reporting period.

The State will determine each SCDMH hospital's Medicaid routine per diem cost by first summing the inpatient hospital routine service cost centers and dividing this amount by total inpatient hospital days. The routine service costs will be derived from worksheet B, Part I, column 25 (which includes GME cost, if applicable). Total inpatient hospital days and subprovider days (if applicable) will be obtained from Worksheet S-3, Part 1. Any subprovider cost identified as a non inpatient hospital cost (e.g. Psychiatric Residential Treatment Facility (PRTF)) will be excluded from the calculation of the inpatient hospital's routine cost. Next, in order to determine the Medicaid inpatient hospital ancillary service costs, Medicaid covered inpatient ancillary

charges obtained from Medicaid worksheet D-4 will be multiplied