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State/Territory Name: South Carolina

State Plan Amendment (SPA) #: 12-014

This file contains the following documents in the order listed:

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

Financial Management Group

Mr. Christian L. Soura
Interim Director
Department of Health and Human Services
P.O. Box 8206
Columbia, South Carolina 29202-8206

RE: State Plan Amendment (SPA) SC 12-014

Dear Mr. Soura:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid state plan submitted under transmittal number (TN) 12-014. Effective October 1, 2012 this amendment proposes to revise the payment methodology for long term care psychiatric hospitals and psychiatric residential treatment facilities. Specifically, this amendment proposes to eliminate retrospective cost settlement and establish prospective per diem rates based of the providers most recent cost report trended to the rate year ending September 2013.

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 October 1, 2012. 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//

Timothy Hill
Director

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 12-014

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
Oovember 1, 2012

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:
CFR 42, Page 447

7. FEDERAL BUDGET IMPACT: Rates are projected to estimate allowable Medicaid costs
a. FFY 2013 $0
b. FFY 2014 $0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-A Pages 1, 2a, 3, 4, 12, 13, 14, 15, 17, 19, 23, 24, 34 35, 36, 37, 38, 39

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Attachment 4.19-A, Pages 1, 2a, 3, 4, 12, 13, 14, 15, 17,19, 23, 24, 34, 35, 36, 37, 38, 39

10. SUBJECT OF AMENDMENT:
Prospective payment rates for long term psychiatric hospitals effective October 1, 2012

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:
//s//

13. TYPED NAME:
Anthony E. Keck

14. TITLE: Director

15. DATE SUBMITTED: 12/18/12

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:
12/27/12

18. DATE APPROVED: 01/27/15

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
10/01/12

20. SIGNATURE OF REGIONAL OFFICIAL:
//s//

21. TYPED NAME:
Timothy Hill

22. TITLE: Director

23. REMARKS: State authorized pen and ink change to block #4

Block #4 changed to read: 10/1/12.

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;

2. a prospective reimbursement system for all other acute and non-acute care hospitals providing inpatient hospital services including all long-term psychiatric hospitals (i.e. both private and governmental);

3. a prospective payment reimbursement system for private and governmental psychiatric residential treatment facilities.

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

will be retrospectively cost settled at eighty-seven.three percent (87.3%) of allowable SC Medicaid inpatient hospital DME (including the DME capital related costs) and IME costs. Effective for discharges incurred on or after October 1, 2011, SC large rural hospitals as defined by Rural/Urban Commuting Area classes with total licensed beds of 90 or less will be exempted from the July 11, 2011 payment reductions.

d) Effective for discharges occurring on or after July 11, 2011, SC general acute care hospitals designated as SC critical access hospitals or those identified as SC isolated rural and small rural hospitals as defined by Rural/Urban Commuting Area classes will continue to receive retrospective cost settlements that represent ninety-seven percent (97%) of allowable SC Medicaid inpatient costs which includes base, capital, DME and IME costs. Additionally, certain SC large rural hospitals as defined by Rural/Urban Commuting Area classes and are located in a Health Professional Shortage Area (HPSA) for primary care for total population will continue to receive ninety-seven percent (97%) of allowable SC Medicaid inpatient costs which includes base, capital, DME and IME costs. Effective for discharges incurred on or after October 1, 2011, SC large rural hospitals as defined by Rural/Urban Commuting Area classes with total licensed beds of 90 or less will receive retrospective cost settlements that represent ninety-seven percent (97%) of allowable SC Medicaid costs which include base, capital, DME and IME costs.

e) All qualifying hospitals that employ a burn intensive care unit and contract with the SC Medicaid Program will receive an annual retrospective cost settlement for inpatient services provided to SC Medicaid patients. Effective for discharges occurring on or after July 11, 2011, the retrospective cost settlement amount for qualifying hospitals with a burn intensive care unit will continue to be limited to ninety-seven percent (97%) of allowable SC Medicaid inpatient costs which includes base, capital, DME and IME costs. In order for a hospital to qualify under this scenario, a hospital must:

   a. Be located in South Carolina or within 25 miles of the South Carolina border;

   b. Have a current contract with the South Carolina Medicaid Program; and

   c. Have at least 25 beds in its burn intensive care unit.

f) Effective for services provided on or after October 1, 2012, all SC contracting non-state owned governmental long-term care psychiatric hospitals and all contracting SC long-term psychiatric hospitals owned by the SC Department of Mental Health will receive prospective per diem payment rates.

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

5. An outlier set-aside adjustment (to cover outlier payments described in 9 of this section) will be made to the per discharge rates.

6. Payment for services provided in private freestanding long-term care psychiatric facilities shall be based on the statewide average per diem for psychiatric long-term care provided by governmental providers.

7. The payments determined under both payment methods, the DRG payment system for general acute care hospitals, including acute psychiatric and rehabilitation units, long term acute care hospitals, and short term care psychiatric hospitals and the per diem method for psychiatric long-term care facilities, will be adjusted to recognize facility specific costs associated with direct and indirect medical education, capital and ancillary services as appropriate. In addition to the claims payment, hospitals may receive other payments as outlined in this Attachment. Some examples are as follows: Section VI I describes hospital cost settlements and Section VII describes Disproportionate Share Hospital payments.

8. Special payment provisions, as provided in Section VI A of this plan, will be available under the DRG payment system for discharges which are atypical in terms of costs of services provided during the stay. These cases will be referred to as outliers. Special payment policies, as specified in Section VI B and C of this plan, will also be made for cases involving a transfer of a patient from one hospital to another, or a readmission of a patient following an earlier discharge. These provisions are not applicable to long-term psychiatric and RTF claims.

9. A rate reconsideration process will be available to hospitals that have higher costs as a result of conditions described in IX A of this plan.

10. Disproportionate share payments will be paid to qualifying hospitals in accordance with the requirements specified in Section VII of this plan.

11. Payment for services provided in psychiatric residential treatment facilities shall be an all-inclusive per diem rate. Section II paragraph 30 of this plan defines the costs covered by the all- inclusive rate. Each facility's per diem rate will be calculated using base year data trended forward. Section V B describes the rate calculation.

12. Effective for services provided on or after July 1, 2004, qualifying hospitals with burn intensive care units will receive annual retrospective cost settlements for the total cost ofinpatient services provided to South Carolina Medicaid patients.

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.

13. Effective for dates of service on or after October 1, 2011, qualifying hospitals that meet the criteria of Section VI(N) or VI(O) will receive quarterly supplemental enhanced payments for fee-for-service inpatient hospital services.

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 of data used for calculation of payment rates. For the hybrid payment system rates effective on and after July 11, 2011, the base year shall be each facility's 2006 fiscal year. For the freestanding governmental long-term psychiatric hospital rates, the base year shall be each facility's 2010 (state owned governmental) or 2011 (non-state owned governmental) 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.

3. The SC Medicaid inpatient cost-to-charge ratio, which reflects 100% of allowable Medicaid costs (including DME and IME) will be determined by taking the sum of the SC Medicaid routine service costs and inpatient ancillary costs and dividing this amount by the sum of the SC Medicaid covered routine service charges and inpatient covered ancillary charges.
4. Next, for non teaching hospitals, the inpatient hospital cost to charge ratio as determined in step 3. above will be reduced by either the April 8, 2011 payment reduction amount (i.e.3% of all costs) or by the July 11, 2011 payment reduction amount (i.e. 7% of all costs) as defined under Section I. (C), Overview of Reimbursement Principles, paragraphs (1) b., c., d., and e.

5. Next, for teaching hospitals as defined by the state plan, the inpatient hospital cost to charge ratio as determined in step 3. above will need to be broken out into two inpatient hospital cost to charge ratios consisting of base operating costs (including capital) and Graduate Medical Education costs (including Direct and Indirect). Therefore, Direct Medical Education costs as reported on worksheet B Part I are identified and removed from total allowable facility costs as reported under worksheet B, Part I, column 25 to determine base operating costs. Next, to determine the amount of Indirect Medical Education costs of teaching hospitals with an intern and resident training program, the base operating costs previously described will be multiplied by the Indirect Medical Education formula described in Section II 16. The amount of Indirect Medical Education costs as determined in this computation will be removed from base operating costs and then added to the amount of Direct Medical Education costs to determine Graduate Medical Education costs. Next, routine per diems and ancillary cost to charge ratios will be developed for both base operating costs and Graduate Medical Education costs based upon the methodology previously described in this section and multiplied by covered Medicaid inpatient hospital days and covered Medicaid inpatient ancillary charges to determine two Medicaid cost pools - one for base operating costs and one for Graduate Medical Education costs. Next, in order to determine the Medicaid allowable inpatient hospital cost, the individual cost pools will be reduced by either the April 8, 2011 payment reduction amount (i.e. 3% of all costs) or by the July 11, 2011 payment reduction amount (i.e. 7% on base and 12.7% or 0% on Graduate Medical Education costs) as defined under Section I. (C), Overview of Reimbursement Principles, paragraphs (1) b., c., d., and e. Finally, the two adjusted Medicaid cost pools will be summed and divided by total Medicaid inpatient hospital covered charges to determine the Medicaid inpatient hospital cost to charge ratio for use in the October 1, 2011 rate setting.

In a separate computation, a cost per day will be determined for prospective reimbursement for all free-standing long-term care psychiatric facilities based on 2010 or 2011 cost report data for services provided on or after October 1, 2012.

C. Inflation

1. DRG Payment System

For the DRG payment system rates effective October 1, 2011, no trend factor will be applied.

D. DRG Relative Weights

The relative weights used for calculating reimbursement for hospitals paid under the DRG payment system will be the corresponding national relative weights (released in October 2010) of version 28 of the APR-DRG grouper. Relative weights will be reviewed annually and updated as needed at the same time as the DRG grouper is updated.

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 the period July 1, 2010 through June 30, 2011 by the DRG relative weight, summing these amounts and dividing by the sum of the total per case discharges. Version 28 of the APR-DRG grouper and the corresponding national relative weights (released in October 2010) were used in the calculation of the case mix index for each hospital.

F. 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. Effective for services provided on or after October 1, 2012 both state owned and non-state owned governmental PRTFs will receive prospective reimbursement based upon its FY 2010 cost reporting period trended to the October 1, 2012 payment period.

V. Reimbursement Rates

A. Inpatient Hospital

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

1. Hospital Specific Per Discharge Rates

The following methodology is employed in the computation of the hospital specific per discharge rates effective October 1, 2011:

a. The hospital specific per discharge rates will continue to be calculated so that DRG based interim payments approximate the Department's specified percent of allowable Medicaid costs for each eligible hospital as described under section VI (I).

b. The adjusted hospital fiscal year 2010 Medicaid inpatient hospital cost to charge ratio of each hospital, as described in Section IV. (B) (4) and (5), is multiplied by each hospital's Medicaid inpatient hospital covered charges based upon discharges incurred during the period July 1, 2010 through June 30, 2011.

2. Per Diem Prospective Payment Rate - Long-Term Psychiatric Hospitals Effective October 1, 2012

Only free-standing governmental long-term care psychiatric hospitals are included in this computation.

a) Total allowable Medicaid costs are determined for each state owned governmental long term psychiatric hospital using its fiscal year 2010 Medicaid cost report. Allowable costs would include both routine and ancillary services covered by the long term psychiatric hospital. For the one non-state owned governmental long term psychiatric hospital that came on line in July 2010, the hospital's fiscal year 2011 cost report will be used to determine total allowable Medicaid reimbursable costs as described above.

b) Next, total patient days incurred by each hospital during its cost reporting period were obtained from each provider's Medicaid cost report.

c) Next, in order to determine the per diem cost for each governmental long term psychiatric hospital, total allowable Medicaid reimbursable costs for each provider is divided by the number of patient days incurred by the provider to arrive at its per diem cost.

d) Finally, in order to trend the governmental long term psychiatric hospitals base year per diem cost (i.e. July 1, 2009 through June 30, 2010 or July 1, 2010 through June 30, 2011) to the payment period (i.e. October 1, 2012 through September 30, 2013) using the midpoint to midpoint methodology, the agency employed the use of the applicable CMS Market Basket Rates for Inpatient Psychiatric Facilities:

RY 2010- 2.1%
RY 2011- 2.4%

e) For private long term psychiatric hospitals that do not receive a hospital specific per diem rate, a statewide per diem rate will be developed by first multiplying the governmental long term psychiatric hospitals per diem rate by the Medicaid patient days incurred during its base year cost reporting period. Next, the sum of the Medicaid allowable cost amounts for all governmental long term psychiatric hospitals was divided by the sum of the incurred Medicaid patient days to determine the statewide per diem rate to be reimbursed to private long term psychiatric hospitals effective October 1, 2012.

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

Effective for services provided on or after October 1, 2012, the prospective per diem rate will be determined in a two-step process. First, total allowable Medicaid cost will be divided by total actual patient days based upon the FY 2010 Medicaid cost report. No occupancy adjustment factor will be applied. Next, the FY 2010 per diem cost will then be trended forward to the midpoint of the October 1, 2012 through September 30, 2013 payment period using the midpoint to midpoint methodology and the 2010 Medicare I/P Psych Hospital Market Basket Rate (2.10%) to determine the prospective per diem rate.

3. Non-State Government Owned and Operated Facility Rate

Effective for services provided on or after October 1, 2012, the prospective per diem rate will be determined in a two-step process. First, 97% of total allowable Medicaid cost will be divided by total actual patient days based upon the FY 2010 Medicaid cost report. No occupancy adjustment factor will be applied. Next, the FY 2010 per diem cost will then be trended forward to the midpoint of the October 1, 2012 through September 30, 2013 payment period using the midpoint to midpoint methodology and the 2010 Medicare I/P Psych Hospital Market Basket Rate (2.10%) to determine the prospective per diem rate.

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

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 hospital's adjusted cost for a claim exceeds the sum of the DRG threshold and DRG reimbursement. For hospitals which receive its own hospital specific per discharge rate, the hospital's adjusted cost is derived by applying the adjusted hospital specific cost to charge ratio used in the October 1, 2011 rate setting to the hospital's allowed claim charges. For hospitals that receive the statewide average per discharge rate, the hospital's adjusted cost is derived by applying the adjusted statewide cost to charge ratio of .2879 effective October 1, 2011.

b. The cost outlier thresholds were calculated using the following methodology:

- Inpatient hospital claims with a discharge date incurred during July 1, 2009 through June 30, 2010 served as the basis for the cost outlier threshold calculations.
- Calculate the average cost and standard deviation for
- If a DRG has 25 or more stays, set the initial cost outlier threshold at the average cost plus two standard deviations.
- For DRGs with 25 or more stays, calculate the median ratio of the calculated threshold to the average cost. The result from this dataset is 2.30.

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

G. Payment for One-Day Stay

Reimbursement for one-day stays (except deaths, false labor (565-1 to 565-4), normal deliveries (560-1 to 560-4 and 541-1 to 541-4)) and normal newborns (640-1 to 640-4)) 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.

H. 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 DRG 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).

b. For private freestanding long-term care psychiatric facilities, payment will be at the statewide average per diem for long term care psychiatric facilities.

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

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

interns/residents and allied health alliance training programs will be retrospectively cost settled at eighty-seven.three percent (87.3%) of allowable SC Medicaid inpatient hospital DME (including the DME capital related costs) and IME costs.

- Effective for discharges occurring on or after July 11, 2011, SC general acute care hospitals designated as SC critical access hospitals or those identified as SC isolated rural and small rural hospitals as defined by Rural/Urban Commuting Area classes will continue to receive retrospective cost settlements that represent ninety-seven percent (97%) of allowable SC Medicaid inpatient costs which includes base, capital, DME and IME costs. Additionally, certain SC large rural hospitals as defined by Rural/Urban Commuting Area classes and are located in a Health Professional Shortage Area (HPSA) for primary care for total population will continue to receive ninety-seven percent (97%) of allowable SC Medicaid inpatient costs which includes base, capital, DME and IME costs.

- Effective for discharges incurred on or after October 1, 2011, SC large rural hospitals as defined by Rural/Urban Commuting Area classes with total licensed beds of 90 or less will receive retrospective cost settlements that represent ninety-seven percent (97%) of allowable SC Medicaid costs which include base, capital, DME and IME 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 or after July 11, 2011, the retrospective cost settlement amount for qualifying hospitals with a burn intensive care unit will continue to be limited to ninety-seven percent (97%) of allowable SC Medicaid inpatient costs which includes base, capital, DME and IME 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. However, effective for discharges occurring on or after July 11, 2011 by contracting out of state border hospitals that have SC Medicaid fee for service inpatient claims,

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 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** 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-3 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.** 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 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 24 (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-3 will be multiplied

by the applicable ''cost'' cost to charge ratio(s) by ancillary cost center reflected on Worksheet C. Therefore, to determine each hospital's allowable Medicaid inpatient hospital cost, the Medicaid routine per diem cost will be multiplied by covered Medicaid inpatient days to determine allowable Medicaid inpatient hospital routine costs. The Medicaid days are tied to MMIS paid claims data. The Medicaid allowable inpatient hospital routine cost will then be added to the allowable Medicaid inpatient ancillary costs to determine total allowable Medicaid inpatient hospital costs.
Effective for services provided on or after October 1, 2012, the SCDMH long term psychiatric hospitals will no longer receive retrospective cost settlements. However, because CPE is used as the source of state matching funds, annual cost reconciliations will be performed to ensure that Medicaid payments do not exceed allowable Medicaid costs each cost reporting year. Therefore, the Medicaid inpatient hospital costs as determined above will be compared to Medicaid payments received and applicable (including both fee for service, gross adjustments, third party liability and copayments, if applicable) to services provided during the cost reporting period. The Medicaid days, charges and payments are tied to MMIS paid claims (including gross adjustment payment data). In the event of an underpayment, the Agency will make no payment to the provider. In the event of an overpayment, the Agency will recover only the federal portion of the overpayment. Any difference to the reimbursement amount reflected above will be recorded as an adjustment on the CMS 64 report.

Final Reconciliation of Interim Medicaid Inpatient Hospital Payment Rate Post Reporting Year:

Upon issuance of a Final Audit Report by the Agency's audit contractor of the SCDMH hospital cost reports, the Agency will determine each SCDMH hospital's audited 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 24 (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 audited Medicaid inpatient hospital ancillary service costs, Medicaid covered inpatient ancillary charges obtained from Medicaid worksheet D-3 will be multiplied by the applicable ''cost'' cost to charge ratios by ancillary cost center reflected on Worksheet C. Therefore, to determine each hospital's audited Medicaid inpatient hospital cost, the audited Medicaid routine per diem cost will be multiplied by covered Medicaid inpatient days to determine the audited Medicaid inpatient hospital routine costs. The Medicaid days are tied to MMIS paid claims data. The audited Medicaid inpatient hospital routine cost will then be added to the audited Medicaid inpatient ancillary costs to determine total audited Medicaid inpatient hospital costs. Effective for services provided on or after October 1, 2012, the SCDMH long term psychiatric hospitals will no longer receive retrospective cost settlements. However, because CPE is used as the source of state matching funds, annual cost reconciliations will be performed to ensure that Medicaid payments do not exceed allowable Medicaid costs each cost reporting year. Therefore, the Agency will compare the audited allowable Medicaid inpatient hospital costs against the Medicaid payments received and applicable (including both fee for service, gross adjustments including interim CPE cost recoveries , third party liability and copayments, if applicable) to services provided during the cost reporting period. The Medicaid days, charges and payments that will be used in the final audit settlement will be tied to MMIS paid claims (including gross adjustment payment data). In the event of an underpayment, the

Agency will make an additional payment that when added to the Medicaid fee for service payments and gross adjustments (including CPE reconciliation adjustments) and patient responsibility payments will not exceed the interim Medicaid payment amount as defined above. In the event of an overpayment, the Agency will recover only the federal portion of the overpayment. Any difference to the reimbursement amount reflected above will be recorded as an adjustment on the CMS 64 report.

II. Interim Reconciliation of Interim Medicaid Psychiatric Residential Treatment Facility (PRTF) Payments:

Upon receipt of the SCDMH PRTF's fiscal year end June 30 cost report, the PRTF'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 cost report as filed to the Medicaid Agency for the respective cost reporting period.
The State will determine the SCDMH PRTF's Medicaid per diem cost by first identifying the routine cost of the PRTF (identified as a subprovider) in William S Hall's CMS Form 2552 cost report. This amount will be derived from worksheet B, Part I, column 24 (which includes GME cost, if applicable). Total PRTF (i.e. subprovider) patient days that will be used in the determination of the PRTF's Medicaid per diem cost will be obtained from Worksheet S-3, Part 1. Next, in order to determine the PRTF's portion of the ancillary service costs, Medicaid covered PRTF ancillary charges obtained from Medicaid worksheet D-3 will be multiplied by the applicable ''cost'' cost to charge ratio(s) by ancillary cost center reflected on Worksheet C. Therefore, to determine the PRTF's allowable Medicaid cost, the Medicaid PRTF per diem cost will be multiplied by covered Medicaid PRTF days to determine allowable Medicaid PRTF routine costs. The Medicaid days are tied to MMIS paid claims data. The Medicaid allowable PRTF routine cost will then be added to the allowable Medicaid PRTF ancillary costs to determine total allowable Medicaid PRTF costs.

Effective for services provided on or after October 1, 2012, the SCDMH PRTF will no longer receive retrospective cost settlements. However, because CPE is used as the source of state matching funds, annual cost reconciliations will be performed to ensure that Medicaid payments do not exceed allowable Medicaid costs each cost reporting year. Therefore, the Medicaid PRTF costs as determined above will be compared to Medicaid payments received and applicable (including both fee for service, gross adjustments, third party liability and copayments, if applicable) to services provided during the cost reporting period. In the event of an underpayment, the Agency will make no payment to the provider. In the event of an overpayment, the Agency will recover only the federal portion of the overpayment. Any difference to the reimbursement amount reflected above will be recorded as an adjustment on the CMS 64 report.

Final Reconciliation of Interim Medicaid Psychiatric Residential Treatment Facility (PRTF) Payment Rate Post Reporting Year: Upon issuance of a Final Audit Report by the Agency's audit contractor of the SCDMH hospital/PRTF cost reports, the Agency will determine the SCDMH PRTF's audited Medicaid routine per diem cost by first identifying the PRTF's routine service cost center and dividing this amount by total PRTF patient days. The PRTF routine service cost will be derived from worksheet B, Part I, column 24 (which includes GME cost, if applicable). Total PRTF patient days

will be obtained from Worksheet S-3, Part 1. Next, in order to determine the audited Medicaid PRTF ancillary service costs, Medicaid covered PRTF ancillary charges obtained from Medicaid worksheet D-3 will be multiplied by the applicable "cost" cost to charge ratios by ancillary cost center reflected on Worksheet C. Therefore, to determine the PRTF's audited Medicaid cost, the audited Medicaid PRTF routine per diem cost will be multiplied by covered Medicaid PRTF patient days to determine the audited Medicaid PRTF routine costs. The Medicaid days are tied to MMIS paid claims data. The audited Medicaid PRTF routine cost will then be added to the audited Medicaid PRTF ancillary costs to determine total audited Medicaid PRTF costs. Effective for services provided on or after October 1, 2012, the SCDMH PRTF will no longer receive retrospective cost settlements. However, because CPE is used as the source of state matching funds, annual cost reconciliations will be performed to ensure that Medicaid payments do not exceed allowable Medicaid costs each cost reporting year. Therefore, the Agency will compare the audited Medicaid PRTF costs against the Medicaid payments received and applicable (including both fee for service, gross adjustments including interim CPE cost recoveries, third party liability and copayments, if applicable) to services provided during the cost reporting period. The Medicaid days and payments, including claim and gross adjustment payments, that will be used in the final audit settlement will be tied to MMIS paid claims data. In the event of an underpayment, the Agency will make an additional payment that when added to the Medicaid fee for service payments and gross adjustments (including CPE reconciliation adjustments) and patient responsibility payments will not exceed the interim Medicaid payment amount as defined above. In the event of an overpayment, the Agency will recover only the federal portion of the overpayment. Any difference to the reimbursement amount reflected above will be recorded as an adjustment on the CMS 64 report.

Cost of the uninsured

III. Calculation of Interim Disproportionate Share Hospital (DSH) Limit:

A base year will be used to calculate the cost of the SC uninsured, Medicaid managed care enrollees, dual (Medicare/Medicaid) eligibles, and Medicaid eligibles who have inpatient hospital services reimbursed by a commercial insurance carrier. The base year will be the SCDMH hospitals fiscal year end beginning two years prior to the reporting year (ex. 2009 data for federal fiscal year (FFY) 2011 DSH payments). Interim DSH Limit for each SCDMH hospital will be the estimated uncompensated care for inpatient hospital services provided to all individuals with no source of third party insurance (i.e. SC and out-of state uninsured), and Medicaid fee for service individuals plus the uncompensated care (including potential surplus) for inpatient hospital services provided to Medicaid managed care enrollees, dual (Medicare/Medicaid) eligibles, and Medicaid eligibles who have inpatient and outpatient hospital services reimbursed by a commercial carrier.

This computation of establishing interim DSH payments funded by CPEs must be performed on an annual basis and in a manner consistent with the instructions below.

a) Using the CMS Form 2552 cost report for the fiscal year ending during the fiscal year data being used (ex. 2009 data for FFY 2011 DSH payments), an allowable routine per diem cost will be calculated for each SCDMH hospital for DSH

payment purposes. The state will determine each SCDMH hospital's DSH eligible routine per diem cost by first summing the inpatient hospital routine service cost centers. These amounts will be derived from worksheet B, Part I, column 24 (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 DSH eligible inpatient hospital ancillary service costs associated with all uninsured Medicaid fee for service, Medicaid managed care enrollees, dual (Medicare/Medicaid) eligibles, and Medicaid eligibles who have inpatient hospital services reimbursed by a commercial insurance carrier, covered inpatient ancillary charges by ancillary cost center and payor class obtained from the annual SC Medicaid DSH Survey will be multiplied by the applicable ''cost'' cost to charge ratio(s) by ancillary cost center reflected on Worksheet C. Therefore, to determine each hospital's DSH eligible allowable inpatient hospital cost, the DSH eligible routine per diem cost will be multiplied by all DSH eligible inpatient days to determine allowable DSH eligible inpatient hospital routine costs. The DSH eligible days will be obtained from the annual SC Medicaid DSH Survey. The DSH eligible allowable inpatient hospital routine cost will then be added to the DSH eligible allowable inpatient ancillary costs to determine total allowable DSH eligible inpatient hospital costs.

b) The inpatient hospital cost associated with the South Carolina uninsured and Medicaid eligibles as described above will be trended using the CMS Market Basket Index as described in section VII. of Attachment 4.19-A. The trended cost will then be reduced by payments received from uninsured patients as well as payments received on behalf of inpatient hospital services provided to Medicaid eligibles as described above to determine each hospital's estimated maximum amount of uncompensated care costs to be reimbursed during the DSH payment period.

c) The uncompensated care cost as described above will be used in the development of the interim DSH payment amount as described in section VII of Attachment 4.19-A.

d) Final Reconciliation of Interim Medicaid DSH Payments Post Reporting Year: Upon issuance of a Final Audit Report by the Agency's audit contractor beginning with the October 1, 2010 DSH Payment Program, the Agency will determine each SCDMH hospital's audited DSH eligible routine per diem cost by first summing the inpatient hospital routine service cost centers. These amounts will be derived from worksheet B, Part I, column 24 (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 DSH eligible inpatient hospital audited ancillary service costs associated with the uninsured and Medicaid eligibles (i.e. Medicaid fee for service individuals, Medicaid managed care enrollees, dual (Medicare/Medicaid) eligibles, and Medicaid eligibles who have inpatient hospital services reimbursed by a commercial insurance carrier), covered inpatient ancillary charges by ancillary cost center by payor class will be multiplied by the applicable ''cost'' cost to charge ratio(s) by ancillary cost center reflected on Worksheet C. Therefore, to determine each hospital's audited DSH eligible inpatient hospital cost, the audited DSH eligible routine per diem cost will be multiplied by DSH eligible inpatient hospital days to determine audited DSH eligible inpatient hospital routine costs. The DSH eligible audited inpatient hospital routine cost will then be added to the DSH eligible audited inpatient ancillary costs to determine total audited DSH eligible inpatient hospital costs. The total audited DSH eligible inpatient hospital cost will then be reduced by payments received from uninsured patients as well as payments received on behalf of inpatient hospital services provided to Medicaid eligibles as described above to determine each hospital's audited hospital specific DSH limit for the DSH payment period. The redistribution of DSH payments that will take place beginning with the October 1, 2010 through September 30, 2011 DSH payment period will be described in section IX(C)(1)(b) of Attachment 4.19-A. However, SCDMH DSH hospitals cannot receive any more FFY 2010/2011 DSH payments than the maximum amount allowed under section VII(A)(1)(iv) of Attachment 4.19-A. In the event of a DSH underpayment, the Agency will reimburse the provider only the federal portion of the underpayment. In the event of a DSH overpayment, the Agency will recover only the federal portion of the overpayment.