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State/Territory Name: South Carolina

State Plan Amendment (SPA) #: 17-0010

This file contains the following documents in the order listed:

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

Financial Management Group

October 30, 2017

Ms. Deirdra T. Singleton
Acting Director
Department of Health and Human Services
P.O. Box 8206
Columbia, South Carolina 29202-8206

RE: South Carolina State Plan Amendment 17-0010

Dear Ms. Singleton:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid state plan submitted under transmittal number (TN) 17-0010. Effective July 1, 2017, this amendment modifies the State's reimbursement methodology for setting payment rates for Psychiatric Residential Treatment Facilities. Specifically, this amendment will eliminate the all-inclusive rate and pay for core facility services, room and board, psychological training, testing, and assessment services on a per diem basis. All ancillary services will be billed separate to the Medicaid agency and paid based on a fee schedule. The per diem rates for core services will be determined based on each facilities fiscal year end 2015 cost report trended to July 1, 2017 by 2.7 percent.

We conducted our review of your submittal according to the statutory requirements at sections 190 2(a), 1 902(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 July 1, 2017. 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//

Kristin Fan
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: 17-0010	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 July 1, 2017	

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

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN x ☐ 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: a. FFY 2017 $267,000 b. FFY 2018 $1,074,000 $
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 3.1-A, Page 7 Attachment 3.1-F, page 13 Attachment 4.19-A, pages 3,8, 9, 10,15,18,19,23,34,36 and 37 **(pages 17a and 19a are being deleted from State Plan due to language Shift in SPA-11-026** Attachment 4.19-C	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Attachment 3.1-A, Page 7 Attachment 3.1-F, page 13 Attachment 4.19-A, pages 3,8, 9, 10,15,18,19,23,34,36 and 37 Attachment 4.19-C

10. SUBJECT OF AMENDMENT: This plan amendment eliminates the "all-inclusive rate" payment methodology previously employed by the Medicaid Agency and provides for a rate update effective July 1, 2017 for PRTF core services as well as the implementation of PRTF services and providers in the Coordinated Care benefit provided by SCDHHS' contracted Managed Care Organizations.

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
x☐ OTHER, AS SPECIFIED:
Ms. Singleton was designated by the Governor to review and approve all State Plans

12. SIGNATURE OF STATE AGENCY OFFICIAL: //s//	16. RETURN TO: South Carolina Department of Health and Human Services P.O. Box 8206 Columbia, South Carolina 29202-8206
13. TYPED NAME: Deirdra T. Singleton	
14. TITLE: Acting Director	
15. DATE SUBMITTED: August 10, 2017	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 08/14/17	18. DATE APPROVED: 10/30/17
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: 07/01/17	20. SIGNATURE OF REGIONAL OFFICIAL: //s//
21. TYPED NAME: Kristin Fan	22. TITLE: Director, FMG

23. REMARKS:

State/Territory South Carolina

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

15. a. Intermediate care facility services for the intellectually disabled for persons determined in accordance with section 1902(a)(31)(A) of the Act, to be in need of such care.

[X] Provided [ ] No limitations

[X] With limitations* [ ] Not Provided:

16. a. Inpatient psychiatric facility services for individuals under 22 years of age.

[X] Provided [ ] No limitations

[X] With limitations* [ ] Not Provided:

b. Psychiatric Residential Treatment facility services for individuals under 22 years of age.

[X] Provided [ ] No limitations

[X] With limitations* [ ] Not Provided:

17. Nurse-midwife services

[X] Provided [ ] No limitations

[X] With limitations* [ ] Not Provided:

18. Hospice care (in accordance with section 1905(o) of the Act).

[X] Provided [X] No limitations [X] Provided in accordance with section 2302 of the Affordable Care Act

[ ] With limitations* [ ] Not Provided:

*Description provided on attachment

Citation	Condition or Requirement
	√ The state assures that beneficiary requests for disenrollment (with and without cause) will be permitted in accordance with 42 CFR 438.56(c).
	4. Describe any additional circumstances of "cause" for disenrollment (if any). The State does not use any additional circumstances of "cause" for disenrollment other than those detailed in 42 CFR 438.56(c).
	K. Information requirements for beneficiaries Place a check mark to affirm state compliance.
1932(a)(5) 42 CFR 438.50 42 CFR 438.10	√ The state assures that its state plan program is in compliance with 42 CFR 438.10(i) for information requirements specific to MCOs and PCCM programs operated under section 1932(a)(1)(A)(i) state plan amendments. (Place a check mark to affirm state compliance.)
1932(a)(5)(D) 1905(t)	L. List all services that are excluded for each model (MCO & PCCM) PCCM excluded services: None MCO excluded services: Institutional Long Term Care Facilities/Nursing (after the first ninety (90) continuous days post- admission) Non-Ambulance Transportation Glasses, contacts and fitting fees Dental Services Targeted Case Management Services Pregnancy Prevention Services – Targeted Populations MAPPS Family Planning Services Organ Transplantation Non mental health services provided by a School District Services provided by the Department of Disabilities and Special Needs Services provided in Developmental Evaluation Centers Services provided in free standing psychiatric hospital services Prescribed drugs, or classes of drugs, that are excluded from the MCO capitation rate
1932 (a)(1)(A)(ii)	M. Selective contracting under a 1932 state plan option To respond to items #1 and #2, place a check mark. The third item requires a brief narrative. 1. The state will __/will not √ _____ intentionally limit the number of entities it contracts under a 1932 state plan option.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of South Carolina

RESERVED BED POLICY

The following is a description of the methods that apply to the established standards for reserved bed.

I. For Inpatient Hospitalization

a. Nursing Facilities - Bed reservations for Nursing Facilities are allowed for a period of 10 days.

b. Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) - Bed reservations for an ICF/IID facility are for a period of 10 days.

II. Nursing Facilities may reserve beds in their facilities for up to nine (9) days at a time not to exceed eighteen (18) days per fiscal year for documented therapeutic reasons or as a trail of home care as part of a documented plan of deinstitutionalization.

An additional 30 days consecutive leave will be allowed for the purpose of participating in an approved rehabilitation program such as an evaluation and training program through the S.C. Department of Vocational Rehabilitation when a patient has been officially accepted into the program.

III. Long Term Care/(ICF/IID) - Long Term Care/(ICF/IID) facilities may authorize leave of absence for residents of their facilities for eight days per month as a part of their rehabilitative plans of care. However, a one-time 30 day consecutive leave per admission will be allowed for discharge planning in permanent placement to a home environment. This leave must be prescribed by the attending physician as a vital part of the discharge planning activity. Leaves of absence exceeding eight days per month or 30 days for discharge planning will require a discharge from the facility and re-admittance.

IV. Psychiatric Residential Treatment Facilities - Psychiatric Residential Treatment Facilities may authorize a therapeutic leave for a beneficiary to spend time at home. This is referred to as Therapeutic Home Time; beneficiaries may receive up to fourteen days of Therapeutic Home Time per fiscal year. Facilities will receive a full per diem for Therapeutic Home Time. Therapeutic Home Time is part of a therapeutic plan to transition the youth to a less restrictive level of care.

RO APPROVAL: OCT 30 2017
SUPRSEDES: MA 90-33

5. Effective for discharges incurred on and after October 1, 2015, the Medicaid Agency will reimburse inpatient hospital services using version 32 of the All Patient Refined Diagnosis Related Groups (APR-DRGs) classification system. Qualified providers of inpatient hospital services paid by APR-DRGs include: general acute care hospitals (including distinct part units of general acute care hospitals), short term psychiatric hospitals, and long term acute care hospitals. Version 32 of the APR-DRG grouper and corresponding national relative weight will be used effective October 1, 2015.

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

7. Payment for services provided in private freestanding long term care psychiatric facilities that contract with the SC Medicaid Program for the first time or reenter the SC Medicaid Program effective on and after November 1, 2013 shall be based on the provider's desk reviewed cost report rate but cannot exceed the statewide average per diem rate of the governmental psychiatric long-term care providers in existence at the time the new private provider enters the Medicaid program.

8. 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.

9. 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.

10. 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.

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

12. Payment for services provided in psychiatric residential treatment facilities (PRTFs) will represent core facility services including room and board as well as psychological training, testing, and assessment services. All medically related ancillary services as well as the psychiatric pharmaceutical costs incurred by Medicaid recipients residing in PRTFs will not be the responsibility of the PRTF but will be billed by the ancillary service provider to the state Medicaid program.

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

25. Mars - Management and Administration Reporting System

26. Medicaid Day Utilization Percentage - A facility's percent of hospital Medicaid eligible inpatient acute days, including Medicaid managed care days, dual eligible (Medicare/Medicaid) days, and Medicaid with commercial insurance days plus administrative days divided by total hospital inpatient acute days plus administrative days. The source of patient day information will be the filed CMS-2552 worksheet S-3, DHHS's MARS report, DHHS's administrative days report and requested supplemental worksheets.

27. Medically Necessary Services - Services which are necessary for the diagnosis, or treatment of disease, illness, or injury, and which meet accepted standards of medical practice. A medically necessary service must:

    a. Be appropriate to the illness or injury for which it is performed as to type and intensity of the service and setting of treatment;

    b. Provide essential and appropriate information when used for diagnostic purposes; and

    c. Provide additional essential and appropriate information when a diagnostic procedure is used with other such procedures.

28. Non-General Acute Care Hospital - A hospital which is certified/licensed as a free standing short term or long term psychiatric hospital or a long term care hospital (LTCH).

29. Outlier - A cost outlier occurs when a patient's charges (converted to cost) exceed a specified amount above the base DRG payment. The hospital will receive reimbursement for the outlier in addition to the base DRG payment. The cost outlier payment methodology is described in Section VI of this plan.

30. Outpatient - A patient who is receiving services at a hospital which does not admit him/her and which is not providing him/her with room and board services.

31. Outpatient Services - Those diagnostic, therapeutic, rehabilitative, or palliative items or services furnished by or under the direction of a physician or dentist to an outpatient by an institution licensed and certified as a hospital. This service will include both scheduled services and the provision of service on an emergency basis in an area meeting licensing and certification criteria.

32. Principal Diagnosis - The diagnosis established after medical evaluation to be chiefly responsible for causing the patient's admission to the hospital.

33. Psychiatric Distinct Part - A unit where psychiatric services are provided within a licensed and certified hospital. Patients in these units will be reimbursed through the DRG payment system.

34. Psychiatric Residential Treatment Facility - An accredited institution primarily engaged in providing psychiatric services for the diagnosis and treatment of mentally ill persons (21 years and under) who require less than hospital services. Medicare certification is not required. Effective April 1, 1994 in-state psychiatric residential treatment facilities are required to be licensed by DHEC in order to receive Medicaid reimbursement as described in the State Plan. Facilities must comply with provisions of 42 CFR Subpart G regarding conditions of participation, restraint and

seclusion.

Attachment 3.1-C, page 9. Psychiatric Residential Treatment Facilities are neither acute care nor long-term care facilities. A Psychiatric Residential Treatment Facility is a facility that is accredited by the Joint Commission of Accreditation of Health Care Organizations (JCAHO), The Council on Accreditation of Services to Families and Children (COA), or The Commission on Accreditation of Rehabilitation Facilities (CARF) operated for the primary purpose of providing active treatment services for mental illness in a non-hospital based residential setting to persons under 21 years of age. Facilities must meet the federal regulations for inpatient psychiatric services at 42 CFR 440.160 and Subpart D for Part 441. Length of stay in a Psychiatric Residential Treatment Facility may range from one (1) month to more than twelve (12) months depending upon the individual's psychiatric condition as reviewed every 30 days by a physician.

35. Short Term Care Psychiatric Hospital - A licensed, certified hospital providing psychiatric services to patients with average lengths of stay of twenty-five (25) days or less. Patients in these hospitals will be reimbursed through the DRG payment system.

36. South Carolina Defined Rural Hospitals - Effective for inpatient and outpatient hospital services incurred/provided on or after October 1, 2014, the South Carolina Department of Health and Human Services has updated its designation of South Carolina (SC) defined rural hospitals. SC defined rural hospitals will included all SC Critical Access Hospitals (CAH); all SC hospitals located in the state's Zip Code Tabulation Areas (ZCTAs) classified as Moderately Rural/Rural; all SC hospitals located in Primary Care Health Professional Shortage Areas (HPSAs) for Total Population; SC hospitals located in Persistent Poverty Counties with ≤130 Licensed Beds; and SC hospitals located in Equally Rural/Urban ZCTAs with ≤90 Licensed Beds. ZCTAs are classed as Rural or Urban based on their population designations as defined by the 2010 Census. Each rural/urban classification reflects the relative proportion of ZCTA residents living in rural versus urban areas. These classifications are as follows:

- Urban: 80.0% to 100.0% Urban
- Moderately Urban: 60.0% to 79.9% Urban
- Equally Rural/Urban: 40.1% to 59.9% Rural/Urban
- Moderately Rural: 60.0% to 79.9% Rural
- Rural: 80.0% to 100.0% Rural

The percentage of the population that is not Urban is considered Rural by the US Census.

37. Special Care Unit - A unit as defined in 42 CFR 413.53 (d).

38. Standard Deviation - The square root of the sum of the squares of the deviation from the mean in a frequency distribution.

39. Teaching Hospital - A licensed certified hospital currently operating an approved intern and resident teaching program or a licensed certified hospital currently operating an approved nursing or allied health education program.

III. Services Included in the Hybrid Payment System

1. Acute Care Hospitals

The DRG payment system rates will include all services provided in an acute inpatient setting except:

a. Professional component, including physician and CRNA services and any other professional fees excluded under Part A Medicare.

b. Ambulance, including neonatal intensive care transport.

2. Psychiatric Residential Treatment Facilities

The per diem reimbursement rate will be determined in accordance with section V.B. of Attachment 4.19-A.

IV. Data Sources and Preparation of Data for Computation of DRG Payment System Rates

Computation of the October 1, 2015 DRG payment system rates under this plan will require the collection and preparation of the following data elements: per discharge DRG list including relative weights, Medicaid inpatient cost to charge ratios adjusted for April 8, 2011 and July 11, 2011 reimbursement changes, July 1, 2012 through June 30, 2013 incurred inpatient hospital claims, October 1, 2014 inpatient hospital rates adjusted by the October 1, 2015 normalization adjustment, hospital specific add-ons, case mix index, and an upcode adjustment factor.

A description of the source documents for the required data elements and the steps necessary for preparing the data for the rate computation described in Section V of this plan is presented in the following subsections.

A. Per Discharge DRG List

The DRG payment system will establish payment based upon a hospital specific and/or statewide average per discharge rate. Effective for discharges incurred on or after October 1, 2015, the Medicaid Agency will determine inpatient hospital claim payments based upon the DRG listing contained within version 32 of the APR-DRG grouper. Hospitals eligible to receive a hospital specific per discharge rate will include all SC general acute care hospitals, burn intensive care unit hospitals, and out of state border hospitals with SC Medicaid inpatient utilization of at least 200 inpatient claims during its HFY 2011 cost reporting period. Additionally, SC free standing short term psychiatric hospitals and SC long term acute care hospitals, with a minimum SC Medicaid inpatient utilization of at least 10 incurred claims during October 1, 2011 through August 31, 2012, will also receive a hospital specific per discharge rate. All other contracting/enrolled hospitals (i.e. out of state general acute care, new SC general acute care hospitals coming on line after 2011, and all other short term psychiatric and long term acute care hospitals) will receive the appropriate statewide average rate for that type of hospital. The statewide average rate will exclude DME and IME costs.

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, 2012 through June 30, 2013 by the DRG relative weight, summing these amounts and dividing by the sum of the total per case discharges. Version 32 of the APR-DRG grouper and the corresponding national relative weights were used in the calculation of the case mix index for each hospital.

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.

1. Hospital Specific Per Discharge Rates Effective October 1, 2015:

The following methodology is employed in the computation of the hospital specific per discharge rates effective October 1, 2015:

a. First, the October 1, 2014 hospital specific per discharge rates under version 28 of the APR-DRG grouper were adjusted to account for the October 1, 2015 inpatient hospital normalization adjustment. Effective for discharges incurred on and after October 1, 2015, the Medicaid agency will cap the base component of the hospital specific per discharge rates of the SC general acute care hospitals, SC short term psychiatric hospitals, and qualifying out of state border general acute care hospitals that receive a hospital specific per discharge rate at the 65th percentile of the October 1, 2014 base rate component of the SC general acute care hospitals and the SC long term acute care hospitals. The Graduate Medical Education (Direct Medical Education and Indirect Medical Education) rate components of the hospital specific per discharge rate will not be impacted by this change. For hospitals whose base component of its hospital specific per discharge rate falls below the 15th percentile of the October 1, 2014 base rate component, these hospitals will be reimbursed at the 15th percentile base rate component. However, any teaching hospital with a medical education add-on and whose base rate component falls below the 15th percentile will continue to receive their current base rate component of their October 1, 2014 hospital specific per discharge rate.

B. Psychiatric Residential Treatment Facility

Effective for services provided on and after July 1, 2017, a per diem rate will be calculated for each contracting psychiatric residential treatment facility (PRTF) based upon each PRTF's fiscal year end 2015 base year cost and statistical data as reported on the CMS 2552 cost report. Allowable Medicaid reimbursable costs will be determined in accordance with the Provider Reimbursement Manual HIM-15. The per diem rate will cover all core PRTF services (including all psychiatric related services that normally would be rendered in an outpatient setting such as in Community Mental Health Clinics or Rehabilitative Behavioral Health Service providers) and room and board costs. All other ancillary costs (including medical ancillary services and psychiatric drugs) will be carved out of the per diem rate and the billing for the ancillary services will become the responsibility of the ancillary provider. An occupancy adjustment will be applied if the base year occupancy rate is less than the statewide average occupancy rate. For rates effective July 1, 2017, the statewide average occupancy rate is eighty-six percent (86%).

In the event that a PRTF's pre July 1, 2017 rate is greater than the provider's July 1, 2017 per diem cost with all ancillary service costs included, the Medicaid agency will grandfather the rates of these providers by determining the provider's per diem ancillary cost that was incurred and reported in the provider's fiscal year end 2015 cost report and then removing this per diem ancillary cost amount from the provider's pre July 1, 2017 SC Medicaid PRTF rate. For PRTFs that do not receive a grandfathered rate, their base year per diem cost will be trended by 2.70%.

The above payment methodology applies to private, non-state owned governmental, and state owned governmental PRTF providers. PRTFs entering the SC Medicaid program on and after July 1, 2017 will receive the July 1, 2017 statewide average SC Medicaid PRTF 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 November 1, 2012 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 .2754 effective November 1, 2012.

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

- Inpatient hospital claims with a discharge date incurred during July 1, 2012 through June 30, 2013 served as the basis for the cost outlier threshold calculations.
- Calculate the average cost and standard deviation for each DRG.
- 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.

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 Psychiatric Residential Treatment Facilities (PRTFs), payments will be based on a statewide average of all the PRTF rates.

I. Retrospective Hospital Cost Settlements

Effective for services provided on or after October 1, 2014, 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.

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

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

ii. There will be no retrospective cost adjustment for PRTFs 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

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

II. 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