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State/Territory Name: South Carolina

State Plan Amendment (SPA) #: 11-014

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTI-l & 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 and CHIP Services

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

FEB -8 2012

RE: State Plan Amendment SC ll-014

Dear Mr. Keck:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 11-014. Effective July 11, 2011 this amendment proposes to revise the inpatient hospital payment methodologies. Specifically, payment rates for services provided on or after July 11, 2011 will be reduced to ninety three percent (93%) of the rates in effect on October 1, 2010 except for the state government hospitals. In addition, reimbursement for graduate medical education (GME) for in-state hospitals will be reduced an additional 10%, payments for GME to out of state hospitals will be eliminated, and payments for hospital acquired conditions will be eliminated. Also, these reductions shall not apply to critical access hospitals, isolated rural and small rural hospitals, large rural hospitals as defined by the Rural/Urban Commuting Areas classes and hospital services provided by qualifying bum intensive care unit hospitals.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a), 1902(a)(l3), 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 11, 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 11-014

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
07/11/11

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 $(5.200,000)
b. FFY 2012 $(20,900,000)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-A, pages 2, 2a, 2b, 4, 9, 16, 17, 17a, 18, 19, 19a, 21, 25, 26, 26a, 29 and 29a

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Attachment 4.19-A, pages 2, 2a, 4, 9, 16, 17, 18, 19, 21, 25, 26, and 29

10. SUBJECT OF AMENDMENT:
Inpatient hospital payment reductions effective July 11, 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:
//s//

13. TYPED NAME:
Anthony E. Keck

14. TITLE:
Director

15. DATE SUBMITTED:
July 12 , 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: 07/14/11

18. DATE APPROVED: 02/08/12

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 7/11/11

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

21. TYPED NAME:
Cindy Mann

22. TITLE:
Director, CMS

23. REMARKS: Approved with following changes as authorized by state agency:

Block # 8 changed to read: Attachment 4.19-A, pages 2, 2a, 2b, 4, 9, 16, 17, 17a, 18, 19, 19a, 21, 25, 26, 26a, 29 and 29a; Supplement 1 to attachment 4.19-A pages 1 and 2; Supplement 2 to attachment 4.19-A pages 1, 2 and 3.

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. 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 utilization of at least 200 claims, an annual analysis will be performed each cost reporting year to ensure that Medicaid reimbursement does not exceed ninety-three percent (93%) of allowable SC Medicaid inpatient costs relating to base as well as all capital related costs except for the capital associated with Direct Medical Education (DME). DME costs (including the capital related portion) and Indirect Medical Education (IME) costs associated with interns/residents and allied health alliance training programs will no longer be considered an allowable Medicaid reimbursable cost for out of state border hospitals. For inpatient hospital discharges occurring on or after July 11, 2011 by SC long term acute care hospitals, free standing short-term psychiatric hospitals, and free standing long-term psychiatric hospitals, an annual analysis will be performed each cost reporting year to ensure that Medicaid reimbursement does not exceed ninety-three percent (93%) of allowable SC Medicaid inpatient costs relating to base as well as all capital related costs except for the capital associated with DME. The DME and IME cost component of the SC long term acute care hospitals and the SC freestanding short-term and long-term psychiatric hospitals associated with interns/residents and allied health alliance training programs will be recognized at eighty-seven.three percent (87.3%) of allowable SC Medicaid inpatient hospital DME costs (including the DME capital related portion) and IME costs in this analysis.

c) 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), 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.

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.

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) Retrospective inpatient cost settlements will be determined for 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. Retrospective cost settlements will be limited to one-hundred percent (100%) 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 July 11, 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.

28. 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 hybrid payment system.

29. Psychiatric Residential Treatment Facility - An institution primarily engaged in providing psychiatric services for the diagnosis and treatment of mentally ill persons 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 State Plan 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.

30. Psychiatric Residential Treatment Facility All-Inclusive Rate - The all-inclusive rate will provide reimbursement for all treatment related to the psychiatric stay, psychiatric professional fees, and all drugs prescribed and dispensed to a client while residing in the Residential Treatment Facility.

31. 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 hybrid payment system.

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

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

34. 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.

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 or after July 11, 2011, the per discharge rate" for each nonteaching general acute care hospital except for 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 located in a Health Professional Shortage Area (HPSA) for primary care for total population, and qualifying burn intensive care unit hospitals will represent ninety-three percent (93%) of the October 1, 2010 "actual per discharge rate". SC critical access hospitals. SC isolated rural and small rural hospitals, certain SC large rural hospitals located in a Health Professional Shortage Area (HPSA) for primary care for total population and qualifying burn intensive care unit hospitals will continue to receive ninety-seven percent (97%) of the October 1, 2010 "actual per discharge rate". 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 utilization of at least 200 claims, the per discharge rate will represent ninety-three percent (93%) of the October 1, 2010 "actual per discharge rate" relating to base as well as all capital related costs except for the capital associated with Direct Medical Education (DME) DME costs (including the capital related portion) and Indirect Medical Education (IME) costs associated with interns/residents and allied health alliance training programs

will no longer be considered an allowable Medicaid reimbursable cost for out of state border hospitals. Effective for discharges occurring on or after July 11, 2011, all out of state hospitals will receive the non teaching statewide per discharge rate even though the hospital may be designated as a teaching hospital. Effective for discharges occurring on or after July 11, 2011, SC teaching hospitals per discharge rate will represent ninety-three percent (93%) of the October 1, 2010 "actual per discharge rate" relating to base as well as all capital related costs except for the capital associated with Direct Medical Education (DME). DME costs (including the capital related portion) and Indirect Medical Education (IME) costs associated with interns/residents and allied health alliance training programs will be reimbursed at eighty seven.three percent of the October 1, 2010 add-on amounts. 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. Effective for discharges occurring on and after July 11, 2011, the statewide per discharge rate will represent ninety-three percent (93%) of the October 1, 2010 "actual per discharge rate" relating to base as well as all capital related costs except for the capital associated with Direct Medical Education (DME). DME costs (including the capital related portion) and Indirect Medical Education (IME) costs associated with interns/residents and allied health alliance training programs will no longer be considered an allowable Medicaid reimbursable cost for out of state hospitals. SC teaching hospitals per discharge rate will represent ninety-three percent (93%) of the October 1, 2010 "actual per discharge rate" relating to base as well as all capital related costs except for the capital associated with Direct Medical Education (DME). DME costs (including the capital related portion) and Indirect Medical Education (IME) costs associated with interns/residents and allied health alliance training programs will be reimbursed at eighty seven.three percent of the October 1, 2010 add-on amounts.

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. Effective for discharges occurring on and after July 11, 2011, all out of state hospitals will receive the non-teaching per diem rates even though they may be designated as a teaching hospital.

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 or after July 11, 2011, the hospital specific per diem multiplier for each nonteaching general acute care hospital except for 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 located in a Health Professional Shortage Area (HPSA) for primary care for total population, and qualifying burn intensive care unit hospitals will represent ninety-three percent (93%) of the October 1, 2010 hospital specific per diem multiplier. SC critical access hospitals. SC isolated rural and small rural hospitals, certain SC large rural hospitals located in a Health Professional Shortage Area (HPSA) for primary care for total population and qualifying burn intensive care unit hospitals will continue to receive ninety-seven percent (97%) of the October 1, 2010 hospital specific per diem multiplier. 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 utilization of at least 200 claims, the hospital specific per diem multiplier will be adjusted to represent ninety-three percent (93%) of the October 1, 2010 per diem multiplier relating to base as well as all capital related costs except for the capital associated with Direct Medical Education (DME). DME costs (including the capital related portion) and Indirect Medical Education (IME) costs associated with interns/residents and allied health alliance training programs will no longer be considered an allowable Medicaid reimbursable cost for out of state border hospitals and thus will not be considered in the computation of the July 11, 2011 hospital specific per diem multiplier. Effective for discharges occurring on or after July 11, 2011, SC teaching hospitals hospital specific per diem multiplier will represent ninety-three percent (93%) of the October 1, 2010 hospital specific per diem multiplier relating to base as well as all capital related costs except for the capital associated with Direct Medical Education (DME). The July 11, 2011 hospital specific per diem multiplier will also recognize DME costs (including the capital related portion) and Indirect Medical Education (IME) costs associated with interns/residents and allied health alliance training programs at eighty seven.three percent of the October 1, 2010 add-on amounts . Effective for discharges occurring on and after July 11, 2011, all other contracting hospitals will receive an inpatient per multiplier of .93. 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. Effective for services provided on and after July 11, 2011, the long-term psych hospitals per diem rate will represent ninety-three percent (93%) of the October 1, 2010 per diem rate relating to base as well as all capital related costs except for the capital associated with Direct Medical Education (DME). DME costs (including the capital related portion) and Indirect Medical Education (IME) costs associated with interns/residents and allied health alliance training programs will no longer be considered an allowable Medicaid reimbursable cost for out of state long term psych hospitals. SC long term psych teaching hospitals per diem rate will represent ninety-three percent (93%) of the October 1, 2010 per diem rate relating to base as well as all capital related costs except for the capital associated with Direct Medical Education (DME). DME costs (including the capital related portion) and Indirect Medical Education (IME) costs associated with interns/residents and allied health alliance training programs will be reimbursed at eighty-seven.three percent (87.3%) of the October 1, 2010 add-on amounts.

d. Governmental long-term care psychiatric hospitals will not be impacted by this change.

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 July 11, 2011 is .3310.

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.

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 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), 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.

- 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.

- 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.

- 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. 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 utilization of at least 200 claims, an annual analysis will be performed each cost reporting year to ensure that Medicaid reimbursement does not exceed ninety-three percent (93%) of allowable SC Medicaid inpatient costs relating to base as well as all capital related costs except for the capital associated with Direct Medical Education (DME). DME costs (including the capital

related portion) and Indirect Medical Education (IME) costs associated with interns/residents and allied health alliance training programs will no longer be considered an allowable Medicaid reimbursable cost for out of state border hospitals. For inpatient hospital discharges occurring on or after July 11, 2011 by SC long term acute care hospitals, free standing short-term psychiatric hospitals, and free standing long-term psychiatric hospitals, an annual analysis will be performed each cost reporting year to ensure that Medicaid reimbursement does not exceed ninety-three percent (93%) of allowable SC Medicaid inpatient costs relating to base as well as all capital related costs except for the capital associated with DME. The DME and IME cost component of the SC long term acute care hospitals and the SC freestanding short-term and long-term psychiatric hospitals associated with interns/residents and allied health alliance training programs will be recognized at eighty-seven.three percent (87.3%) of allowable SC Medicaid inpatient hospital DME costs (including the DME capital related portion) and IME costs in this analysis.

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).

N. Adjustment to Payment for Hospital Acquired Conditions (HACs)

Effective for discharges occurring on or after July 1, 2011, the South Carolina Medicaid Agency will no longer reimburse hospitals for treatment related to Hospital Acquired Conditions as defined by Medicare. Therefore, while the current Grouper employed by the Medicaid Agency can not adjust the interim fee for service claim payment, the HAC recoupment process will be implemented as part of the retrospective cost settlement process. During this process, the SC Medicaid Agency or its designee will identify those inpatient hospital claims with HACs using Grouper version APR-28 and reduce the covered Medicaid inpatient hospital claim charges used for cost settlement purposes by the percentage change in the relative weight.

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. Effective for services provided on or after July 11, 2011, two sets of routine cost per diems and ancillary cost to charge ratios will be determined for teaching hospitals. The first set of routine cost per diems and ancillary cost to charge ratios will be determined on base and all capital related costs except those associated with DME capital costs using the methodology previously described. The second set of routine cost per diems and ancillary cost to charge ratios will be determined using DME (including the capital portion of DME costs) and IME costs determined under the Medicare formula using the methodology previously described. The applicable reductions (i.e. 93% or 97% to base and capital and 0% or 87.3% to DME and IME) will be applied to the calculated cost for each cost pool and an adjusted cost to charge ratio will be determined.

Total allowable Medicaid cost prior to the application of the applicable cost recovery percentage will be determined at the time of cost settlement by multiplying the adjusted 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.

The interim retrospective cost settlement amount will be determined by subtracting payments received from the allowable adjusted 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.

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;

State Plan Under Title XIX of the Social Security Act

Medical Assistance Program

State: South Carolina

Citation

42 CFR 447, 434, 438, and 1902(a)(4), 1902(a)(6), and 1903

Payment Adjustment for Provider Preventable Conditions

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4),1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

Health Care-Acquired Conditions

The State identifies the following Health Care-Acquired Conditions for non-payment under Section 4.19 (A)

__X__ Hospital-Acquired Conditions as identified by Medicare other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients.

Effective July 11, 2011, Medicaid will make zero payments to providers for services related to Provider Preventable Conditions (PPC) which includes Healthcare Acquired Conditions (HCAC). Reimbursement for conditions described above is defined in Attachment 4.19-A, Page 26a of this State Plan

State Plan Under Title XIX of the Social Security Act

Medical Assistance Program

State: South Carolina

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Section(s) Attachment 4.19-A.

__X__ Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

Also consistent with the requirements of 42 CFR 447.26(c).

(c)(2) No reduction in payment for a provider preventable condition will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.

(c)(3) Reductions in provider payment may be limited to the extent that the following apply:

i. The identified provider-preventable conditions would otherwise result in an increase in payment.

ii. The State can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the provider-preventable conditions.

(c)(5) Non-payment of provider-preventable conditions shall not prevent access to services for Medicaid beneficiaries.

State Plan Under Title XIX of the Social Security Act

Medical Assistance Program

State: South Carolina

Citation

42 CFR 447, 434, 438, and 1902(a)(4), 1902(a)(6), and 1903

Payment Adjustment for Provider Preventable Conditions

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4),1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

Health Care-Acquired Conditions

The State identifies the following Health Care-Acquired Conditions for non-payment under Section 4.19 (A)

__X__ Hospital-Acquired Conditions as identified by Medicare other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients.

Effective July 11, 2011, Medicaid will make zero payments to providers for services related to Provider Preventable Conditions (PPC) which includes Healthcare Acquired Conditions (HCAC). Reimbursement for conditions described above is defined in Attachment 4.19-A, Page 26a of this State Plan

State Plan Under Title XIX of the Social Security Act

Medical Assistance Program

State: South Carolina

Citation

42 CFR 447, 434, 438, and 1902(a)(4), 1902(a)(6), and 1903

Payment Adjustment for Provider Preventable Conditions

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4),1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Section(s) Attachment 4.19-B of this State Plan.

__X__ Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.
On and after the above effective date, Medicaid will make zero payments to providers for Other Provider-Preventable Conditions which includes Never Events (NE) as defined by the National Coverage Determination (NCD). The Never Events (NE) as defined in the NCD includes Inpatient Hospitals, Outpatient Hospitals, Ambulatory Surgical Centers (ASC) and practitioners, and these providers will be required to report NEs. Reimbursement for conditions described above will be defined in Attachment 4.19-B, of this State Plan.

Also consistent with the requirements of 42 CFR 447.26(c).

(c)(2) No reduction in payment for a provider preventable condition will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.

(c)(3) Reductions in provider payment may be limited to the extent that the following apply:

i. The identified provider-preventable conditions would otherwise result in an increase in payment.
ii. The State can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the provider-preventable conditions.

(c)(5) Non-payment of provider-preventable conditions shall not prevent access to services for Medicaid beneficiaries.

State Plan Under Title XIX of the Social Security Act

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State: South Carolina

_____ Additional Other Provider Preventable Conditions identified below (please indicate the Section(s) of the plan and specific service type and provider type to which the provisions will be applied.