STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF SOUTH CAROLINA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE
(Reference Attachment 3.1-A)

2.a. OUTPATIENT HOSPITAL SERVICES

I. General Provisions

A. Outpatient Hospital Reimbursement and Upper Payment Limit (UPL) Provision

This plan establishes the methods and standards for reimbursement of outpatient hospital services effective October 1, 2007. Under this plan, a retrospective reimbursement system will be available for the following qualifying hospitals:

- 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 payments (i.e. interim estimated cost settlements paid via gross adjustments), will represent one hundred percent (100%) of each hospital's allowable SC Medicaid outpatient costs.

- 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 outpatient services provided to SC Medicaid patients. 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.

All other hospitals that contract with the SC Medicaid Program for outpatient hospital services will receive prospective payment rates from the statewide outpatient fee schedule. However, for contracting out of state border hospitals that have SC Medicaid fee for service inpatient claims utilization of at least 200 claims and contracting SC long term acute care hospitals, an annual analysis will be performed each cost reporting year to ensure that Medicaid reimbursement under the statewide outpatient fee schedule does not exceed allowable SC Medicaid outpatient costs.

Determination of the Statewide Outpatient Fee Schedule Rates:

The October 1, 2007 statewide outpatient fee schedule rates for acute care and long term acute care hospitals will be based upon the allowable outpatient cost information of covered services from each acute care hospital's FY 2005 cost report. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of outpatient hospital services. The agency's fee schedule rate was set as of October 1, 2007 and is effective for services provided on or after that date. All rates are published on the agency's website. All contracting SC acute care hospitals as well as out of state contracting border hospitals with SC Medicaid fee for service inpatient claims utilization of at least 200 claims were used in this analysis. The source document for Medicaid allowable outpatient costs will be the CMS-2552, which is the Medicare/Medicaid cost report. Allowable Medicaid outpatient costs will be determined in accordance with the Provider Reimbursement Manual Publication 15. However, for clarification purposes, one hundred

percent (100%) of the South Carolina general acute care hospital provider tax will be considered an allowable Medicaid cost. Outpatient allowable costs, charges and statistics will be extracted from the cost report and prepared for the rate computations using the following general guidelines. The FY 2005 SCDHHS MARS paid claims summary data report for each acute care hospital identified above will also be used during the analysis.

- As filed total facility costs are identified from each facility's FY 2005 Worksheet B Part I (BI) CMS-2552 cost report. Total outpatient facility costs would include operating, capital, direct medical education, and indirect medical education costs. CRNA costs identified under BI, column 20 are removed from allowable costs. Observation cost is reclassified.

- As filed total facility costs will be allocated to Medicaid outpatient hospital cost using the following method:

  A cost-to-charge ratio for each ancillary service will be computed by dividing total costs as adjusted in this section by total charges as reported on Worksheet C. This cost-to-charge ratio will then be multiplied by SC Medicaid covered charges (as reported on Worksheet D Part V for Medicaid outpatient ancillary charges) to yield total SC Medicaid outpatient ancillary costs. The SC Medicaid outpatient cost-to-charge ratio will be determined by taking the sum of the SC Medicaid outpatient ancillary costs and dividing this amount by the sum of the SC Medicaid outpatient covered ancillary charges. The SC Medicaid outpatient cost-to-charge ratio will then be multiplied by the facility's SC Medicaid covered outpatient charges as identified on the SCDHHS MARS summary paid claims data report to determine each hospital's allowable SC Medicaid outpatient cost for FY 2005.

- The allowable Medicaid outpatient costs are summed to determine the aggregate Medicaid outpatient costs for FY 2005. An aggregate Medicaid allowable cost target was established at 95% of allowable Medicaid outpatient costs.

- After establishing the FY 2005 aggregate Medicaid allowable cost target, several actuarial models were developed and FY 2005 outpatient claims were repriced to determine the uniform increase in the statewide outpatient fee schedule rates. In order to trend the rates to the period October 1, 2007 through September 30, 2008, a 3.5% annual trend factor was applied. As a result of these steps, the statewide outpatient fee schedule rates increased by 135% effective October 1, 2007.

- In order to convert the statewide outpatient fee schedule rate payment into a hospital specific payment, an outpatient multiplier will be developed for each hospital. The outpatient multiplier will adjust the calculated statewide outpatient fee schedule claims payment to a hospital specific payment and will represent 100% of projected outpatient costs calculated in accordance with Agency defined criteria effective October 1, 2010. Hospitals that receive a hospital specific outpatient multiplier will be those eligible to receive retrospective cost settlements and those contracting out of state border hospitals that have S C Medicaid fee for service inpatient claims

utilization of at least 200 claims. However, the outpatient multiplier for the contracting out of state border hospitals identified above will be set at an amount that will represent 70% of projected October 1, 2010 SC Medicaid outpatient hospital costs. Hospitals that do not qualify for retrospective cost settlements will receive an outpatient multiplier of 1.00. The outpatient multiplier will be applied after the fee schedule payment has been calculated prior to any reduction for third party liability or coinsurance.

- Effective October 1, 2010, all outpatient hospital clinical lab services provided by governmental and private hospitals will be reimbursed at one hundred percent (100%) of the 2010 Medicare Clinical Lab Fee Schedule rates for the State of South Carolina. Therefore, the hospital specific outpatient multiplier described above will no longer be applied in the determination of outpatient hospital clinical lab services reimbursement.

Retrospective Hospital Cost Settlement Methodology:

The following methodology describes the outpatient hospital retrospective cost settlement process for qualifying hospitals. Effective October 1, 2010, outpatient hospital clinical lab services will no longer be retrospectively cost settled.

- A cost-to-charge ratio will be calculated for Medicaid outpatient claims. This ratio will be calculated using cost from worksheet B part I, charges from worksheet C, and Medicaid settlement data from worksheet D part V. 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 aggregate cost-to-charge ratio will be determined by dividing the sum of the calculated Medicaid outpatient ancillary cost by the sum of the Medicaid outpatient charges as reported on worksheet D part V. Charges not covered by the hospital payment system, such as CRNA and ambulance, must be excluded from this calculation.

- Total allowable Medicaid cost will be determined at the time of cost settlement by multiplying the cost-to-charge ratio as calculated in A above, by Medicaid adjusted charges. Medicaid adjusted charges will be 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 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 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 interim cost settlement which could include the submission of one, or a combination of, the following documentation:

a. a more current annual or a less than full year Medicare/Medicaid cost report;
b. an updated outpatient cost-to-charge ratio;
c. an analysis reflecting the financial impact of the reimbursement change effective October 1, 2010.

The provider request will be reviewed by SCDHHS staff to determine if an interim settlement adjustment is justified based upon the best available information at the time.

For clarification purposes, all interim retrospective cost settlements will be subject to final audit. Any underpayment/(overpayment) identified as a result of the final audit will be paid or recouped accordingly.

Upper Payment Limits:

Outpatient hospital reimbursement shall be made in accordance with the upper payment limit requirements defined in 42 CFR 447.321.

Cost Report Requirements:

Cost report requirements under the prospective payment system and retrospective reimbursement system will conform to Medicare cost reporting principles and use as their basis the Medicare Cost Report Form - CMS-2552. In addition, providers must comply with Medicaid specific cost report requirements as published by the DHHS.

Audit Requirements:

All cost report financial and statistical information, the medical information contained on claims and information contained on supplemental worksheets such as the DSH survey, are subject to audit by the DHHS or its designee. The audited information will be used for future rate calculations, retrospective cost settlements, disproportionate share program requirements, utilization review contractor requirements and other analyses.

Co-payment Requirements:

Effective for dates of service March 31, 2004, there is a standard co-payment (42 CFR 447.55) of $3.00 per outpatient non-emergency service furnished in a hospital emergency room when co-payment is applicable (42 CFR 447.53). Emergency services are not subject to co-payment. The outpatient cost settlement payment calculation will include uncollected Medicaid co-payment amounts in accordance with 42 CFR 447.57.

B. Objectives

Implementation of the reimbursement methodology provided herein has the following objectives:

- To encourage outpatient resources be used when they are appropriate substitute for inpatient hospital services.

- To discourage the inappropriateness of outpatient hospital resources as a substitute for physician office and clinic services.

- To ensure the continued existence and stability of the core providers who serve the Medicaid population.

C. Definitions

The following definitions shall apply for the purpose of reimbursement under this plan.

1. Outpatient - A patient who is receiving professional services at a hospital which does not admit him and which does not provide him room and board and professional services on a continuous 24-hour basis.

2. Outpatient services - Those diagnostic, therapeutic, rehabilitative, or palliative items or services furnished by or under the direction of a physician 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.

3. Surgical service – Surgical services are defined as the operative procedures set forth in the ICD – 9-CM surgical procedure codes. Emergency and non-emergency surgical services are included as surgical services.

4. Non surgical services – Emergency or non-emergency services rendered by a physician which do not meet the criteria for surgical or treatment/therapy/testing services.

   a. Emergency services – Services rendered to clients who require immediate medical intervention for an condition for which delay in treatment may result in death or serious impairment.

   b. Non-emergency service – Non-emergency services are defined a scheduled or unscheduled visits to an outpatient hospital clinic or emergency room where a professional service is rendered.

5. Treatment/Therapy/Testing service – Such services are defined as laboratory, radiology, dialysis, physical, speech, occupational, psychiatric, and respiratory therapies and testing services.

II. Scope Of Services

Effective with dates of service July 1, 1988, hospitals certified for participation under the Health Insurance for the Aged Program under Title XVIII of the Social Security Act and participating under the Medicaid Program shall be reimbursed for outpatient services rendered

to eligible clients according to one of three types of outpatient services categories. These categories are prioritized as follows:

A. Surgical services

B. Nonsurgical services

C. Treatment/Therapy/Testing services

A. Surgical Services

1. Services Included in Surgery Payment

Surgical services shall include those outpatient services for which a valid ICD-9-CM surgical procedure code is indicated. For the purposes of reimbursement, surgical services shall be all-inclusive of the services rendered, including but not limited to drugs, anesthesia, IV, blood, supplies, nursing services, operating room, recovery room, prosthesis, etc. Effective October 1, 2010, any outpatient hospital clinical lab services performed under this service category will be separately reimbursed outside of the all-inclusive rate. Physician's services and observation room charges are not included and may be billed separately.

2. Payment Method

a. Surgical services shall be compensated based on the lesser of the charge for services or an all-inclusive fee. ICD-9-CM surgical procedures shall be classified by procedures of similar complexity which consume a like amount of resources. An all-inclusive fee shall be established for each class. However, effective October 1, 2010, any outpatient hospital clinical lab services performed under this service category will be separately reimbursed outside of the all-inclusive rate.

b. Fees for surgical classifications are based on a relationship to the average historical payment made by the state of such procedures as determined from claim history data. ICD-9-CM procedure codes which are not classified under the initial grouping of procedures will be assigned a class by DHHS. Professional medical personnel will be responsible for this function. A procedure may be assigned to an existing classification or a new classification may be created to compensate for the procedure at the discretion of DHHS.

c. In the case of multiple surgeries only one payment will be made. The class producing the highest rate of payment will be selected as the payment rate.

B. Non-surgical Services

1. Services Included in Non-surgical Services Payment

Non-surgical services shall include those scheduled and unscheduled emergency or clinic visits to hospitals which do not meet the criteria for surgical services, but which involve a professional service(s) or direct patient contact other than that associated with a treatment/therapy/testing services. For purposes of reimbursement, non-surgical services shall be all-inclusive of the services rendered, including but not limited to drugs, anesthesia, IV, blood, supplies, nursing services, emergency room, clinic, etc. Effective October 1, 2010, any outpatient hospital clinical lab services performed under this service category will be separately reimbursed outside of the all-inclusive rate. Physician services and observation room charges are not included and may be billed separately.

2. Payment Method

a. Non-surgical services shall be compensated based on the lesser of the charge for services or an all-inclusive fee. ICD-9-CM disease classifications shall be grouped by procedures of similar complexity which consume a like amount of resources. An all inclusive fee shall be established for each class. However, effective October 1, 2010, any outpatient hospital clinical lab services performed under this service category will be separately reimbursed outside of the all-inclusive rate.

b. Fees for non-surgical classifications are based on a relationship to the average historical payment made by the state of such procedures as determined from claim history data. ICD-9-CM diagnostic procedure codes which are not classified under the initial grouping of procedures will be assigned a class by the Commission. Professional medical personnel will be responsible for this function.

A procedure may be assigned to an existing classification or a new classification may be created to compensate for the procedure at the discretion of DHHS.

c. In the case of multiple diagnosis only one payment will be made. The class producing the highest rate of payment will be selected as the payment rate.

C. Treatment/Therapy/Testing Services

The methods and standards for payment of treatment/testing/therapy services are divided into two categories:

- Laboratory and Radiology
- Other Treatment, Therapy and Testing Services

1. Laboratory and Radiology

a. Services Included in Payment Amount

Payment for laboratory and radiology services rendered to outpatients shall consist of a fee for services. Effective October 1, 2010, all outpatient hospital clinical lab services will be reimbursed at one hundred percent (100%) of the 2010 Medicare Clinical Lab Fee Schedule rates for the State of South Carolina. The fee excludes payment for services rendered directly to a patient by a physician (professional).

b. Payment Method

i. Payments for technical radiology and laboratory services shall be made based on the lesser of the charge or fixed fee for each CPT coded procedure.

2. Other Treatment, Therapy and Testing Services

a. Services Included In Payment Amount

Treatment, therapy, and testing services under this part include dialysis treatment, respiratory, physical, speech, occupational, audiological therapies, psychiatric treatment and testing. The payment for each treatment and testing category is a payment per service. Therapy services rendered under this part include the professional services component. If such services are provided in conjunction with surgical or non-surgical services, no separate payment shall be made.

b. Payment Method

Services under this part shall be reimbursed the lesser of the charge for the service or the fixed fee. A fixed fee is assigned for each service type under this part.

III. Utilization Review

1. DHHS shall review the medical necessity of all services rendered under this part. Such review may occur on a pre-or post-payment basis or, at the options of DHHS may occur prior to the rendering of the service. Where such services are determined not medially necessary, payment shall be recovered using the most expedient means, or denied in its entirely.

2. DHHS shall also review the appropriateness of billing for all service types. Such review may occur pre- or post-payment and may produce payment denial or recovery by the most expedient means possible.

IV. Payments to Out-of-State Providers:

Payments to out-of-state providers shall be made based on the lesser of the fixed fee specified for the service or the charge for the service in the case of surgery, nonsurgery or treatment, therapy and testing services.

2b. Rural Health Clinics:

Effective January 1, 2001, in accordance with the requirements of BIPA 2000, an alternative payment methodology will be used for reimbursement of Rural Health Clinics (RHCs). The alternative payment methodology is described below. It has been determined by a comparison of rates using the prospective payment methodology (PPS) and the alternative payment methodology that the alternative methodology as described will provide reimbursement to RHCs which is at least equal to the amount that would be received using the PPS methodology. The FY 01 PPS baseline rates were determined by weighing the RHC specific rates for FYs 1999 and 2000 using Medicare cost principles, by the number of Medicaid encounters provided each year.

Under the alternative payment methodology, reimbursement for medically necessary services will be made at 100% of the all-inclusive rate per encounter as established by the Medicare Intermediary. The Medicare rates shall be obtained from the Medicare Intermediary at the end of the RHC's fiscal reporting period to enable SCDHHS to determine the reimbursement due for the period. Provider-based RHCs with less than fifty (50) beds will receive reimbursement at 100% of Medicare reasonable costs not subject to the RHC rate cap. For provider-based RHCs, actual cost and utilization information based on the RHC's fiscal year shall be obtained from the HCFA-2552-96 actual cost report.

Supplies and injections are not billable services and thus are included in the all-inclusive rate. While family planning contraceptives, the technical component of x-rays and EKGs, diagnostic laboratory services, and the application of fluoride varnish are not considered part of the all-inclusive rate, the services can be billed and reimbursed separately under the appropriate Medicaid fee schedules.

At year-end settlement under the alternative payment methodology, comparisons will be made to assure that the final rate paid based on the RHC's fiscal year will provide reimbursement at least equal to the amount available under the PPS methodology.

Effective January 1, 2004, there is a standard co-payment amount of $2.00 per encounter provided (42 CFR 447.55) when co-payment is applicable (42 CFR 447.53).

Circumstances requiring special consideration/disposition are discussed below:

1. For RHCs not agreeing to the cost based alternative payment methodology, reimbursement for a provider's fiscal year will be based on the provider's PPS FY 01 baseline rate which will be updated annually for: 1) the Medicare Economic Index (MEI) and 2) any increases or decreases in the scope of services furnished by that provider during that fiscal year.