Department of Health & Human Services
Centers for Medicare & Medicaid Services
61 Forsyth Street, SW, Suite 4T20
Atlanta, Georgia 30303-8909

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

June 17, 2011

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

Re: South Carolina Title XIX State Plan Amendment, Transmittal #11-007

Dear Mr. Keck:

We have reviewed the proposed amendment to the South Carolina Medicaid State Plan SC 11-007 that was received in the Regional Office on April 7, 2011. This State plan amendment allows South Carolina Department of Health and Human Services (SCDHHS) to update the hospital specific multiplier to reflect 97% of the October 1, 2010 hospital specific multiplier. This change and approval will reduce the agency's deficit during the state fiscal year which ends on June 30, 2011.

Based on the information provided, we are now ready to approve the Medicaid State Plan Amendment SC 11-007. This SPA was approved on June 16, 2011. The effective date of this amendment is April 8, 2011. We are enclosing the approved form HCFA-179 and plan pages.

If you have any questions, please contact Yvette Moore at 404-562-7327.

Sincerely,

Jackie Glaze

Jackie Glaze
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosures

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 11-007

2. STATE: South Carolina

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

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

4. PROPOSED EFFECTIVE DATE
04/08/11

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

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

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

6. FEDERAL STATUTE/REGULATION CITATION:

42 CFR Part 447 Subpart C

7. FEDERAL BUDGET IMPACT: FMAP
a. FFY 2011 $(1,379,425)
b. FFY 2012 $(3,231,040)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-B, pages 1, 1.1, 1a.1, 1a.2, 1a.3 and 1d

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Attachment 4.19-B, pages 1, 1a.1, 1a.2, and 1d

10. SUBJECT OF AMENDMENT:
Outpatient hospital payment reductions effective April 8, 2011

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

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Anthony E. Keck

14. TITLE:
Director

15. DATE SUBMITTED:
April 7 , 2011

16. RETURN TO:

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

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 4-7-11

18. DATE APPROVED: 06/16/11

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
04/09/11

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: Jackie Glaze

22. TITLE: Associate Regional Administrator
Division of Medicaid & Children's Health Oprns

23. REMARKS:

FORM HCFA-179 (07-92)

Department of Health & Human Services
Centers for Medicare & Medicaid Services
61 Forsyth Street, SW, Suite 4T20
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CENTERS for MEDICARE & MEDICAID SERVICES

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Sincerely,

Jackie Glaze
Associate Regional Administrator
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Enclosures

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. Effective for services provided on and after April 8, 2011, retrospective cost settlements will be limited to ninety-seven percent (97%) of allowable SC Medicaid outpatient costs for all SC general acute care hospitals except for the largest teaching hospital in the state. The largest teaching hospital in the state will continue to receive one hundred percent (100%) of its allowable Medicaid outpatient cost via a retrospective cost settlement. The largest teaching hospital is defined in Attachment 4.19-A, Section II, Paragraph 20.

- 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. Effective for services provided 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 outpatient 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.

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. Effective for services provided on and after April 8, 2011, the annual analysis will be performed to ensure that Medicaid reimbursement under the statewide outpatient fee schedule does not exceed ninety-seven percent (97%) of 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. 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

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. Effective for services provided on and after April 8, 2011, the hospital specific outpatient multipliers will be reduced to reflect ninety-seven percent (97%) of the October 1, 2010 hospital specific outpatient multiplier except for the largest teaching hospital in the state. The largest teaching hospital in the state will continue to receive one hundred percent (100%) of its October 1, 2010 hospital specific outpatient multiplier. Hospitals that do not qualify for retrospective cost settlements will receive an outpatient multiplier of 1.00. Effective for services provided on and after April 8, 2011, hospitals that do not qualify for retrospective cost settlements will receive an outpatient multiplier of .97. 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. Effective for services provided on and after April 8, 2011, all outpatient hospitals clinical lab services except for those provided by the largest teaching hospital in the state will be reimbursed at ninety seven percent (97%) of the 2010 Medicare Clinical Lab Fee Schedule rates for the state of South Carolina. The largest teaching hospital in the state will continue to receive 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. 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 costs. 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 for services provided on and after April 8, 2011.

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:

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:

a. 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.

b. 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. Effective for services provided on and after April 8, 2011, all outpatient hospitals clinical lab services except for those provided by the largest teaching hospital in the state will be reimbursed at ninety seven percent (97%) of the 2010 Medicare Clinical Lab Fee Schedule rates for the state of South Carolina. The largest teaching hospital in the state will continue to receive 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.

ii. The fee for technical radiology or laboratory services is based on a percentage of the amount for a total procedure on the fee schedule for independent radiology or laboratory services.

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.