DEPARTMENT OF HEALTH & 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
CENTER FOR MEDICAID & CHIP SERVICES

APR 25 2013

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

RE: State Plan Amendment SC 13-002

Dear Mr. Keck:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 13-002. This is a technical amendment submitted to remove language inadvertently included, and approved by CMS, in an earlier amendment (SPA 11-026). CMS requested the state submit this amendment to remove this language (recognition of the error arose as CMS was reviewing pending amendment SPA 11-022).

This amendment has an effective date of October 1, 2011, which was also the effective date of SPA 11-026, and SPA 13-002 has no impact on the state's payment methodology or standards. This amendment is only making technical changes that have no effect on coverage or payment and only resolves a technical issue in the state plan. There is no financial impact.

We conducted our review of your submittal according to the statutory requirements at sections, 1902(a), 1902(a)(13), 1902(a)(30), 1903(a) and 1923 of the Social Security Act and the regulations at 42 CFR 447 Subpart C. We have found that the proposed amendment complies with applicable requirements and therefore have approved the plan with an effective date of October 1, 2011. We are enclosing the CMS-179 and the amended approved plan pages.

If you have any questions, please call Anna Dubois at (850) 878-0916.

Sincerely

Cindy Mann
Director

RECEIVED
MAY 03 2013
Department of Health & Human Services
OFFICE OF THE DIRECTOR

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: SC 13-002

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
October 1, 2011

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 Subpart C

7. FEDERAL BUDGET IMPACT: Rates are projected to approximate allowable Medicaid costs.
a. FFY 2012 $0
b. FFY 2013 $0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A, Pages 4, 23 & 26

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-A, Pages 4, 23 & 26

10. SUBJECT OF AMENDMENT:
Technical SPA to remove reimbursement language applicable to 11-022 which was included in the submission of SC 11-026, Inpatient Hospital Reimbursement, and subsequently approved by CMS via the October 23, 2012 approval letter.

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:
February 15, 2013

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:

18. DATE APPROVED: APR 25 2013

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

22. TITLE:

23. REMARKS:

FORM HCFA-179 (07-92)

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 of data used for calculation of payment rates. For the DRG payment system rates effective on and after October 1, 2011, the base year shall be each facility's fiscal year 2010 cost reporting period and incurred inpatient hospital claims for the period July 1, 2010 through June 30, 2011 paid through August 5, 2011. 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.

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

G. Payment for One-Day Stay

Reimbursement for one-day stays (except deaths, false labor (565-1 to 565-4), normal deliveries (560-1 to 560-4 and 541-1 to 541-4)) and normal newborns (640-1 to 640-4)) will be reimbursed a DRG per diem. A DRG per diem is equal to reimbursement for applicable DRG divided by the average length of stay for that DRG.

H. New Facilities/New Medicaid Providers

Payment rates for facilities that were not in operation or not contracting with the SC Medicaid Program during the base year will be determined as follows:

a. For hospitals under the DRG payment system, the per discharge payment rate will be set at the applicable statewide average per discharge rate (i.e. teaching with intern/resident program. teaching without intern/resident program, and non-teaching).

b. For 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.

I. Retrospective Hospital Cost Settlements

Effective for services provided on or after October 1, 2007, the following types of hospitals will receive retrospective Medicaid inpatient cost settlements. In calculating these settlements, allowable cost and payments will be calculated in accordance with the methodology described in Section VIII.

- All SC general acute care hospitals contracting with the SC Medicaid Program that qualify for the SC Medicaid DSH Program will receive retrospective cost settlements that, when added to fee for service and non fee for service (i.e. adjustment) payments will represent one hundred percent (100%) of each hospital's allowable SC Medicaid inpatient costs. However, effective for discharges occurring on or after July 11, 2011, all SC general acute care hospitals except those designated as SC critical access hospitals. SC isolated rural and small rural hospitals as defined by Rural/Urban Commuting Area classes, certain SC large rural hospitals as defined by Rural/Urban Commuting Area classes and located in a Health Professional Shortage Area (HPSA) for primary care for total population, and qualifying burn intensive care unit hospitals which contract with the SC Medicaid Program will receive retrospective cost settlements, that, when added to fee for service and non fee for service payments (i.e. interim estimated cost settlements paid via gross adjustments), 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

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.

Effective for discharges occurring on and after October 1, 2011, payment by DRG may be reduced based on the federal requirements for Medicaid HCAC categories. The APR-DRG software will ignore secondary diagnoses that meet the minimum requirements of the Medicaid HCAC criteria. The list of Medicaid HCAC categories will be reviewed and updated annually. Adjustments will be made during the cost settlement process so that hospital costs associated with Medicaid HCACs are not reimbursed by the Department using the methodology previously described above. Payment by DRG may be disallowed based on the federal requirements for OPPCs. Claims will be identified and subject to quality review when the services provided meet the minimum requirements of OPPCs (e.g., erroneous surgeries). The Medicaid OPPC list will be reviewed and updated annually.