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State/Territory Name: South Carolina

State Plan Amendment (SPA) #: 24-0015

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S3-14-28
Baltimore, Maryland 21244-1850

Financial Management Group

December 19, 2024

Eunice Medina
Interim Director, Department of Health & Human Services
Post Office Box 8206
1801 Main Street
Columbia, SC 29202-8206

RE: TN 24-0015

Dear Director Medina:

The Centers for Medicare & Medicaid Services (CMS) has reviewed the proposed South Carolina state plan amendment (SPA) to Attachment 4.19-A SC-24-0015, which was submitted to CMS on September 30, 2024. This plan amendment updates the reimbursement methodology for free standing short-term psychiatric hospitals, establishes reimbursement for PRTF ASD Treatment Services, and updates rates for PRTF services.

We reviewed your SPA submission for compliance with statutory requirements, including in sections 1902(a)(2), 1902(a)(13), 1902(a)(30), and 1903 as it relates to the identification of an adequate source for the non-federal share of expenditures under the plan, as required by 1902(a)(2) of the Social Security Act and the applicable implementing Federal regulations.

Based upon the information provided by the state, we have approved the amendment with an effective date of July 1, 2024. We are enclosing the approved CMS-179 and a copy of the new state plan pages.

If you have any additional questions or need further assistance, please contact James Francis at 857-357-6378 or via email at James.Francis@cms.hhs.gov.

Sincerely,

Rory Howe

Rory Howe
Director
Financial Management Group

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 24 — 0015

2. STATE: SC

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

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2024

5. FEDERAL STATUTE/REGULATION CITATION
SSA, Sect. 1905(h)(a)(16); 42 CFR 440.160; 42 CFR 482.60

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2024 $ 457,507
b. FFY 2025 $ 1,833,714

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
~~Attachment 3.1-A Limitation Supplement, page 1c.2~~
Attachment ~~4.19-B,~~ 4.19-A pages 1, 2, 3, 4, 9, 17, 18, 23, 34

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
~~Attachment 3.1-A Limitation Supplement, page 1c.2~~
Attachment ~~4.19-B,~~ 4.19-A pages 1, 2, 3, 4, 9, 17, 18, 23, 34

9. SUBJECT OF AMENDMENT

Inpatient Psychiatric Hospitalization and PRTF Rate Updates

10. 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. Kerr was designated by the Governor to review and approve all State Plans.

11. SIGNATURE OF STATE AGENCY OFFICIAL
RM Kerr

12. TYPED NAME
Robert M. Kerr

13. TITLE
Director

14. DATE SUBMITTED
September 30, 2024

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

FOR CMS USE ONLY

16. DATE RECEIVED
September 30, 2024

17. DATE APPROVED
December 19, 2024

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
July 1, 2024

19. SIGNATURE OF APPROVING OFFICIAL
Rory Howe

20. TYPED NAME OF APPROVING OFFICIAL
Rory Howe

21. TITLE OF APPROVING OFFICIAL
Director, Financial Management Group

22. REMARKS

South Carolina authorizes a pen-and-ink change to remove "Attachment 3.1-A Limitation Supplement, page 1c.2" from Blocks 7 and 8. (JGF)
South Carolina authorizes a pen and ink change to blocks 7 and 8 of the 179 form to change Attachment 4.19-B to Attachment 4.19-A. (JGF)

Instructions on Back

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF SOUTH CAROLINA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
INPATIENT HOSPITAL AND PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY CARE

I. General Provisions

A. Purpose

This plan establishes:

1. a retrospective reimbursement system for qualifying burn intensive care unit hospitals as defined in the plan.

2. a prospective reimbursement system for all other acute, SC designated rural hospitals and non-acute care hospitals providing inpatient hospital services including all long-term psychiatric hospitals.

3. a prospective payment reimbursement system for private and governmental psychiatric residential treatment facilities.

4. An all-inclusive per diem reimbursement system for pediatric inpatient rehabilitation units or facilities.

It describes principles to be followed by Title XIX inpatient hospital and psychiatric residential treatment providers and presents the necessary procedures for setting rates, making adjustments, calculating retrospective cost settlements for qualifying acute care hospitals, auditing cost reports and managing the hospital disproportionate share (DSH) program.

B. Objectives

Effective October 1, 1997, the Balanced Budget Act (BBA) of 1997 repeals the OBRA 1981 requirement. In its place, the BBA of 1997 provides for a public process for determination of hospital payment rates. This public process will take place for all changes in payment for inpatient hospital and disproportionate share.

Inpatient hospital reimbursement shall be made in accordance with the upper payment limit requirements of Section 447.272.

C. Overview of Reimbursement Principles

1. The South Carolina Medicaid Program will reimburse qualified providers for inpatient institutional services using one or more of the following methods effective for discharges occurring on or after October 1, 2015:

a. Prospective payment rates will be reimbursed to contracting out-of-state acute care hospitals with SC Medicaid fee for service inpatient claim utilization of less than 200 SC Medicaid fee for service claims during its HFY 2011 cost reporting period via a statewide per discharge rate.

b. Prospective payment rates will be reimbursed to free standing short term psychiatric hospitals that contract with the SC Medicaid Program for the first time or reenter the SC Medicaid Program effective on or after July 1, 2014 via a statewide free standing short term psychiatric hospital statewide average rate (see page 16, section 1.e.).Effective July 1, 2024, free standing short term psychiatric hospitals that contract with the SC Medicaid Program will be reimbursed a per diem of $800 per member per day. This per diem is set at 89% of the 2024 Medicare Inpatient Psychiatric Facilities rate.

c. 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 during its HFY 2011 cost reporting period and all S.C. non-general acute care hospitals (i.e. long-term acute care hospitals, and free standing short-term psychiatric hospitals using a cost target established at 93% prior to July 1, 2024) will be based on a prospective payment system. However, Direct Medical Education (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. The DME and IME cost component of the SC long term acute care hospitals and the SC freestanding short-term psychiatric hospitals prior to July 1, 2024 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 during the rate setting process. Effective for discharges occurring on or after October 1, 2013, the November 1, 2012 base rate component of the out of state border general acute care hospitals with SC Medicaid fee for service utilization of at least 200 claims will be increased by 2.75%. Effective for discharges occurring on or after October 1, 2014, the base rate component of the July 1, 2014 per discharge rate of those hospitals impacted by the July 1, 2014 rate normalization action or the base rate component of the October 1, 2013 per discharge rate of those hospitals not impacted by the July 2014 rate normalization action of the out of state border general acute care hospitals with SC Medicaid fee for service utilization of at least 200 claims will be increased by 2.50%.

d. Effective for discharges occurring on or after October 1, 2014, all SC general acute care hospitals plus qualifying burn intensive care unit hospitals which contract with the SC Medicaid Program will receive prospective payment rates using a cost target established at 93%. However, the DME and IME cost component of these SC general acute care hospitals with intern/resident and allied health alliance programs will be allowed at eighty-seven. three percent (87.3%) of allowable SC Medicaid inpatient hospital DME (including the DME capital related costs) and IME costs during the rate setting process. Effective for discharges occurring on or after October 1, 2014, the base rate component of the July 1, 2014 per discharge rate of those hospitals impacted by the July 1, 2014 rate normalization action or the base rate component of the October 1, 2013 per discharge rate of those hospitals not impacted by the July 2014 rate normalization action of the SC general acute care hospitals other than the SC defined rural hospitals and qualifying burn intensive care unit hospitals will be increased by 2.50%.

e. Effective for discharges occurring on or after July 1, 2023, SC defined rural hospitals (see page 9) which include all SC Critical Access Hospitals (CAH); all SC hospitals located in the state’s Zip Code Tabulation Areas (ZCTAs) classified as Moderately Rural/Rural; all SC hospitals located in Primary Care Health Professional

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

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

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

8. Effective July 1, 2024, free standing short term psychiatric hospitals that contract with the SC Medicaid Program will be reimbursed a per diem of $800 per member per day. This per diem is set at 89% of the 2024 Medicare Inpatient Psychiatric Facilities rates.

9. The payments determined under both payment methods, the DRG payment system for general acute care hospitals, including acute psychiatric and rehabilitation units, and long term acute care hospitals and the per diem method for psychiatric long-term care facilities, and free standing short term care psychiatric hospitals will be adjusted to recognize facility specific costs associated with direct and indirect medical education, capital and ancillary services as appropriate. In addition to the claims payment, hospitals may receive other payments as outlined in this Attachment. Some examples are as follows: Section VI I describes hospital cost settlements and Section VII describes Disproportionate Share Hospital payments.

10. Special payment provisions, as provided in Section VI A of this plan, will be available under the DRG payment system for discharges which are atypical in terms of costs of services provided during the stay. These cases will be referred to as outliers. Special payment policies, as specified in Section VI B and C of this plan, will also be made for cases involving a transfer of a patient from one hospital to another, or a readmission of a patient following an earlier discharge. These provisions are not applicable to long-term psychiatric and RTF claims or to free standing short term care psychiatric hospitals effective July 1, 2024.

11. A rate reconsideration process will be available to hospitals that have higher costs as a result of conditions described in IX A of this plan.

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

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

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

15. Effective for dates of service on or after July 1, 2023, qualifying inpatient rehabilitation units or facilities will receive payment for pediatric inpatient rehabilitation services based on an all-inclusive per-diem methodology for facility charges. Professional services will be reimbursed separately.

16. Effective for dates of service on or after January 1, 2024, hospital-based crisis stabilization observation stays greater than 24 hours will be reimbursed at the 4.19B outpatient payment rate/methodology.

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. Audit Adjustment Factor – An adjustment factor used in the hospital specific Medicaid inpatient hospital rate setting process based upon the results of the HFY 2010 final audit report issued by the SC Medicaid audit contractor.

4. Base Year - The fiscal year used for calculation of payment rates. For the hospital specific inpatient payment rates effective on and after November 1, 2012, the base year shall be each facility's 2011 fiscal year. For the freestanding governmental long-term psychiatric hospital rates, the base year shall be each facility's 2010 (state owned governmental) or 2011 (non-state owned governmental) fiscal year. Effective for services incurred on or after November 1, 2013, the base year used to calculate each freestanding governmental long-term psychiatric hospital rate will be each facility’s 2012 fiscal year cost report.

5. 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.

6. Calibration Adjustment – An adjustment that is used in the Medicaid inpatient hospital rate setting process that takes into account changes in hospital specific cost and hospital case mix and has the effect of increasing or decreasing hospital specific per discharge rates. This factor is also referred to as a “Rate Adjustment Factor”.

7. 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.

8. Case-Mix Index - A relative measure of resource utilization at a hospital.

9. Complex Care Services – Those services rendered to patients that meet the South Carolina level of care criteria for long term care and have multiple needs (i.e. two or more) which fall within the highest ranges of disabilities in the criteria.

10. Cost - Total SC Medicaid allowable costs of inpatient services, unless otherwise specified.

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

35. Short Term Care Psychiatric Hospital - A licensed, certified hospital providing psychiatric services to patients with average lengths of stay of twenty-five (25) days or less. Patients in these hospitals will be reimbursed through the DRG payment system until July 1, 2024. On or after July 1, 2024, these hospitals will be reimbursed through a per diem payment.

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

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

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

    Effective October 1, 2016, an additional SC defined rural hospital criterion was created to include a SC hospital that is located within a "persistent poverty county" as defined in Public Law (P.L.) 112-74 that is not otherwise eligible for higher reimbursement.

    Effective for discharges incurred on and after October 1, 2021, the agency will further protect rural hospitals in South Carolina by allowing hospitals located in a Large Rural Zip Code Tabulation Area (ZCTA) and Primary Care Health Professional Shortage Area (HPSA) for low-income population and has less than or equal to 130 beds to be eligible for retrospective Medicaid cost settlements and DSH reimbursement at 100% of their individual hospital-specific DSH limit. This additional rural hospital criteria will add two hospitals to the South Carolina Defined Rural Hospital list, Cherokee Medical Center and MUSC Health Kershaw Medical Center, and is based upon the results of the May 8, 2014, study conducted by the Division of Policy and Research on Medicaid and Medicare, Institute for Families in Society, University of South Carolina.

    Effective for discharges incurred on and after July 1, 2023, South Carolina Defined rural hospitals will no longer receive retrospective Medicaid cost settlements and will receive a cost based prospective payment rate based on the two-year average of each hospitals 2020 and 2021 payment data applied as a percentage base rate adjustment to the October 1, 2015 inpatient fee schedule.

2. A. Per Diem Prospective Payment Rate - Long-Term Psychiatric Hospitals Effective November 1, 2013.

Only free-standing governmental long-term care psychiatric hospitals are included in this computation.

a) Total allowable Medicaid costs are determined for each governmental long term psychiatric hospital using its fiscal year 2012 Medicaid cost report. Allowable costs would include both routine and ancillary services covered by the long term psychiatric hospital.

b) Next, total patient days incurred by each hospital during its cost reporting period were obtained from each provider's Medicaid cost report.

c) Next, in order to determine the per diem cost for each governmental long term psychiatric hospital, total allowable Medicaid reimbursable costs for each provider is divided by the number of patient days incurred by the provider to arrive at its per diem cost.

d) Finally, in order to trend the governmental long term psychiatric hospitals base year per diem cost (i.e. July 1, 2011 through June 30, 2012 to the payment period (i.e. November 1, 2013 through September 30, 2014)), the agency employed the use of the applicable CMS Market Basket Rates for Inpatient Psychiatric Facilities to determine the trend rate of 5.37%:

RY 2013- 2.7%
RY 2014- 2.6%

e) Effective July 1, 2016, the non-state owned governmental long-term care psychiatric hospital rate was updated based upon its fiscal year end 2015 cost report and trended to the annual payment period using the FY 2016 CMS Market Basket Trend Rate for Inpatient Psychiatric Facilities of 2.4%. Effective October 1, 2017, the state owned governmental long-term care psychiatric hospital rates were updated based upon its fiscal year end 2015 cost report and trended to the payment period using the midpoint to midpoint methodology and the use of the 1st Quarter 2017 Global Insight Indexes – 2012 Based CMS Inpatient Psychiatric Facilities.

f) Effective January 1, 2020, the state owned governmental long-term care psychiatric hospital rates were updated based upon its fiscal year end 2018 cost report and trended to the payment period using the midpoint to midpoint methodology and the use of the 2nd Quarter 2019 Global Insight Indexes - 2016 Based Inpatient Psychiatric Facilities.

g) For services incurred on and after October 1, 2021, the state owned governmental long-term care psychiatric hospital rates were updated based upon its fiscal year 2020 cost report and trended to the payment period using the midpoint to midpoint methodology and the use of the 3rd Quarter 2020 Global Insight Indexes – 2016 Based Inpatient Psychiatric Facilities.

h) For private long term psychiatric hospitals that do not receive a hospital specific per diem rate, a statewide per diem rate will be developed by first multiplying the governmental long term psychiatric hospitals per diem rate by the Medicaid patient days incurred during its base year cost reporting period. Next, the sum of the Medicaid allowable cost amounts for all governmental long term psychiatric hospitals was divided by the sum of the incurred Medicaid patient days to determine the statewide per diem rate for private long term psychiatric hospitals effective November 1, 2013. The hospital will be reimbursed based upon the lesser of its calculated per diem based upon actual costs or the statewide rate.

B. Per Diem Prospective Payment Rate – Free Standing Short Term Psychiatric Hospitals Effective July 1, 2024

Effective July 1, 2024, free standing short term psychiatric hospitals that contract with the SC Medicaid Program will be reimbursed a per diem of $800 per member per day. This per diem is set at 89% of the 2024 Medicare Inpatient Psychiatric Facilities rate.

C. Psychiatric Residential Treatment Facility

Effective for services provided on and after October 1, 2021, a per diem rate will be calculated for each contracting psychiatric residential treatment facility (PRTF) based upon each PRTF's fiscal year end 2019 base year cost and statistical data as reported on the CMS 2552 cost report trended forward to the payment period beginning October 1, 2021 using the midpoint to midpoint trending methodology. Allowable Medicaid reimbursable costs will be determined in accordance with the Provider Reimbursement Manual PRM-15-1 and 42 CFR Part 413. The per diem rate will cover all core PRTF services (including all psychiatric related services that normally would be rendered in an outpatient setting such as in Community Mental Health Clinics or Rehabilitative Behavioral Health Service providers) and room and board costs. All other ancillary costs (including medical ancillary services and psychiatric drugs) will be carved out of the per diem rate and the billing for the ancillary services will become the responsibility of the ancillary provider. No occupancy adjustment will be applied if the base year occupancy rate is less than the statewide average occupancy rate.

The above payment methodology applies to private, non-state owned governmental, and state owned governmental PRTF providers. PRTFs entering the SC Medicaid program on and after October 1, 2021 will receive the statewide average SC Medicaid PRTF rate.

Due to uncontrollable market forces surrounding the South Carolina Medicaid PRTF Program, the Medicaid Agency has reviewed market rates being paid to PRTF providers that contract with the SC Medicaid Program. As a result of our review, effective for services incurred on and after July 1, 2024, the Medicaid Agency will reimburse all contracting privately owned and non-state owned governmental PRTF providers $525 per day.

As Described in Attachment 3.1-A, section 4.b., SCDHHS may designate a PRTF as eligible to provide evidence-based autism spectrum disorder (ASD) Treatment Services. Due to staffing and services costs (including psychological training, testing, and assessment) unique to PRTF ASD Treatment Services, SCDHHS will reimburse all PRTF providers that provide services in private, non-state owned governmental, and state owned governmental SCDHS-designated ASD PRTFs $788 per day for services incurred on or after July 1, 2024.

D. Pediatric Inpatient Rehabilitation Units or Facilities

Effective for services provided on or after July 1, 2023, SCDHHS will reimburse the pediatric inpatient rehabilitation units or facilities a per diem rate in the amount of $1,200. The per diem rate is an all-inclusive and will cover all facility charges, room and board costs, equipment, supplies, drugs, all necessary services and activities rendered during the patient stay. Charges for the professional services of the physician or therapy providers are not included in the rate. The per diem rate is the same for private or state-owned governmental providers qualified to furnish these services.

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

G. Payment for One-Day Stay

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

H. New Facilities/New Medicaid Providers

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

a. For hospitals under the DRG payment system, the per discharge payment rate will be set at the applicable statewide average per discharge rate.

b. For private freestanding long-term care psychiatric facilities, payment will be at the statewide average per diem for long term care psychiatric facilities.

c. For freestanding short term psychiatric facilities, payment will be at the $800 per diem for short term psychiatric facilities.

d. For Psychiatric Residential Treatment Facilities (PRTFs), payment for services incurred on and after July 1, 2024, will be at the $525 per diem for all contracting privately owned and non-state owned governmental PRTF providers. The Medicaid Agency will reimburse all PRTF providers that provide services in private, non-state owned governmental, and state owned governmental SCDHHS-designated ASD PRTFs $788 per day for services incurred on or after July 1, 2024.

I. Retrospective Hospital Cost Settlements

Effective for services provided on or after October 1, 2014, the following types of hospitals will receive retrospective Medicaid inpatient cost settlements. In calculating these settlements, allowable cost and payments will be calculated in accordance with the methodology described in Section VIII.

d. Certified Public Expenditures incurred in providing services to Medicaid and individuals with no source of third party insurance.

The South Carolina Medicaid Agency uses the **CMS Form 2552** cost report for its Medicaid Program and all state owned/operated governmental psychiatric hospitals operated by the South Carolina Department of Mental Health (SCDMH) must submit this report each year. The Agency will utilize worksheet Series S, B, C, and D-3 to determine the cost of inpatient hospital services (no outpatient hospital services provided by SCDMH hospitals) provided to Medicaid eligibles and individuals with no source of third party insurance to be certified as public expenditures (CPE) from the **CMS Form 2552.** This cost report will also be used to determine the cost of Psychiatric Residential Treatment Facility (PRTF) services provided by SCDMH. The Agency will use the procedures outlined below:

Cost of Medicaid

I. Interim Reconciliation of Interim Medicaid Inpatient Hospital Payments:

Upon receipt of the SCDMH hospitals' fiscal year end June 30 cost report, each hospital's interim Medicaid fee for service rate payments and any supplemental payments that may had been made which applied to services provided during the cost reporting period will be reconciled to its CMS Form 2552 cost report as filed to the Medicare Fiscal Intermediary (FI) and Medicaid Agency for the respective cost reporting period.

The State will determine each SCDMH hospital's Medicaid routine per diem cost by first summing the inpatient hospital routine service cost centers and dividing this amount by total inpatient hospital days. The routine service costs will be derived from worksheet B, Part I, column 24 (which includes GME cost, if applicable). Total inpatient hospital days and subprovider days (if applicable) will be obtained from Worksheet S-3, Part 1. Any subprovider cost identified as a non inpatient hospital cost (e.g. Psychiatric Residential Treatment Facility (PRTF)) will be excluded from the calculation of the inpatient hospital's routine cost. Next, in order to determine the Medicaid inpatient hospital ancillary service costs, Medicaid covered inpatient ancillary charges obtained from Medicaid worksheet D-3 will be multiplied