DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, MD 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Financial Management Group

MAR 22 2016

Mr. Christian L. Soura
Director
Department of Health and Human Services
P.O. Box 8206
Columbia, South Carolina 29202-8206

RE: State Plan Amendment SC 14-015

Dear Mr. Soura:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid state plan submitted under transmittal number (TN) 14-015. Effective July 1, 2014 this amendment modifies the state's reimbursement methodology for setting payment rates for inpatient services. Specifically, this amendment will cap the hospital per discharge base rate at the 75 percentile of the October 1, 2013 base rate, increase hospital base rates that fall below the 10th percentile up to the 10th percentile, and for hospitals eligible for retrospective cost settlement cap the payments to the lower of actual allowable cost or the 75th percentile.

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 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 1, 2014. 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,

Kristin Fan
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: 14-015

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
July 1, 2014

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:
a. FFY 2014 $<670,415>
b. FFY 2015 $ <2,684,320>

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-A, pages 2a, 2b, ~~4~~, 16, ~~N~~, 24 & 29
~~Attachment 3.1-A Limitation Supplement, page 1~~

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Attachment 4.19-A, pages 2a, 2b, ~~4~~, 16, ~~N~~, 24 & 29
~~Attachment 3.1-A Limitation Supplement, Page 1~~

10. SUBJECT OF AMENDMENT:
Inpatient Hospital Rate Normalization Project Effective July 1, 2014 and Prospective Per Diem Rates for Free-Standing Rehabilitative Hospitals.

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:
September 30, 2014

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: MAR 22 2016

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JUL 01 2014

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: Kristin FAN

22. TITLE: Director, FMG

23. REMARKS:

FORM HCFA-179 (07-92)

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 or have an average of 35 full time equivalent occupied beds or less based upon hospital fiscal year 2008 thru 2011 cost report census data will continue to receive ninety-seven percent (97%) of allowable SC Medicaid inpatient costs which includes base, capital, DME and IME costs. Interim prospective payment rates will be calculated using a cost target established at 97%. Effective for discharges occurring on or after October 1, 2013, SC general acute care hospitals 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 certain SC large rural hospitals as defined by Rural/Urban Commuting Area classes with an average of 35 full time equivalent occupied beds or less based upon hospital fiscal year 2008 thru 2011 cost report census data will receive retrospective cost settlements that will equal 100% of allowable SC Medicaid inpatient costs which includes base, capital, DME and IME costs. Additionally, for discharges occurring on or after October 1, 2013, the qualifying hospitals identified above will receive a 2.75% increase to their November 1, 2012 interim hospital specific per discharge rate.

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 November 1, 2012, 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. Interim prospective payment rates will be calculated using a cost target established at 97%. Effective for discharges occurring on or after October 1, 2013, qualifying hospitals that employ a burn intensive care unit and contract with the SC Medicaid Program will receive retrospective cost settlements that will equal 100% of allowable SC Medicaid inpatient costs which includes base, capital, DME and IME costs. Additionally, for discharges occurring on or after October 1, 2013, the qualifying hospital identified above will receive 2.75% increase to their November 1, 2012 interim hospital specific per discharge rate. 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. Effective for discharges occurring on or after July 1, 2014, the Medicaid Agency will cap the base component of the hospital specific per discharge rates of the SC general acute care hospitals, SC short term psychiatric hospitals, and qualifying out of state border general acute care hospitals that receive a hospital specific per discharge rate at the 75th percentile of the October 1, 2013 base rate component of the SC general acute care hospitals and the SC long term acute care hospitals. The Graduate Medical Education (Direct Medical Education and Indirect Medical Education) rate components of the hospital specific per discharge rate will not be impacted by this change. For hospitals whose base component of its hospital specific per discharge rate falls below the 10th percentile of the October 1, 2013 base rate component, these hospitals will be reimbursed at the 10th percentile base rate component. However, any teaching hospital with a medical education add-on and whose base rate component falls

below the 10th percentile will continue to receive their current base rate component of their October 1, 2013 hospital specific per discharge rate.

For hospitals that are eligible to receive retrospective cost reimbursement and fall under the 10th percentile, these hospitals will be eligible to receive Medicaid inpatient reimbursement in excess of cost subject to aggregate upper payment limitations. Conversely, hospitals that are eligible to receive retrospective cost reimbursement and are limited by the 75th percentile cap will be reimbursed the lower of allowable actual Medicaid reimbursable inpatient hospital costs or Medicaid inpatient hospital payments at the 75th percentile of the base rate component for discharges occurring on or after July 1, 2014.

g. Effective for services provided on or after October 1, 2012, 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 will receive prospective per diem payment rates.

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. Effective for discharges incurred on and after October 1, 2011, inpatient claim payments for all hospitals (except freestanding long-term care psychiatric hospitals) will be made based on a per discharge (per case) rate.

4. Effective for discharges incurred on or after October 1, 2011, the South Carolina Medicaid Program will reimburse inpatient hospital services based on a DRG methodology using 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 hospitals), short-term psychiatric hospitals and long term acute care hospitals. Version 28 of the APR-DRG grouper and corresponding national relative weights (released in October 2010) will be used effective October 1, 2011. The same version with a mapper will be used for October 1, 2012 since there is a code freeze in effect and minimal impact is expected. The DRG grouper then will transition to the ICD-10 compliant APR-DRG version and will be updated each year to the current version.

c. The Medicaid allowable inpatient cost determined in b) above is reduced by one and a half percent (1.5%) to determine the cost target to be used for each eligible hospital to receive a hospital specific rate. The one and a half percent reduction is applied to take into account the difference between the cost report year and the claims data period.

d. The Medicaid cost target for each hospital determined in c) above will then be compared to each hospital's corresponding Medicaid fee for service claims payments (including co-pay and TPL) paid during the period outlined in b) above to determine the calibration adjustment needed to adjust each hospital's October 1, 2011 hospital specific per discharge rate. For example, if a hospital is a $1,000,000 short of the Medicaid cost target and that facility had $10,000,000 in Medicaid payments, a factor of 1.10 would be applied to its October 1, 2011 Medicaid per discharge rate to determine the November 1, 2012 Medicaid per discharge rate. Conversely, if that same hospital had Medicaid payments of $1,000,000 in excess of the Medicaid cost target, a factor of .90 would be applied to the hospital's October 1, 2011 Medicaid per discharge rate to determine the November 1, 2012 Medicaid per discharge rate.

e. Next, in order to allocate the November 1, 2012 Medicaid per discharge rate for teaching hospitals between the three rate components (i.e. base, DME and IME), the percentage of each component reflected within each teaching hospital's October 1, 2011 per discharge rate will be used to determine the three rate components effective November 1, 2012. Non-teaching hospitals will only have one rate component (i.e. base).

f. Effective for discharges occurring on or after July 1, 2014, the Medicaid Agency will cap the base component of the hospital specific per discharge rates of the SC general acute care hospitals, SC short term psychiatric hospitals, and qualifying out of state border general acute care hospitals that receive a hospital specific per discharge rate at the 75th percentile of the October 1, 2013 base rate component of the SC general acute care hospitals and the SC long term acute care hospitals. The Graduate Medical Education (Direct Medical Education and Indirect Medical Education) rate components of the hospital specific per discharge rate will not be impacted by this change. For hospitals whose base component of its hospital specific per discharge rate falls below the 10th percentile of the October 1, 2013 base rate component, these hospitals will be reimbursed at the 10th percentile base rate component. However, any teaching hospital with a medical education add-on and whose base rate component falls below the 10th percentile will continue to receive their current base rate component of their October 1, 2013 hospital specific per discharge rate.

g. For all other general acute care hospitals that did not receive a hospital specific per discharge rate, a statewide per discharge rate was developed by first multiplying the base operating cost component of each hospital receiving a hospital specific per discharge rate by the total number of its discharges used in the November 1, 2012 rate setting (i.e. October 1, 2011 through August 31, 2012 incurred paid claims). Next, the sum of the calculated base operating cost amounts for all hospitals was divided by the sum of the discharges for all hospitals to determine the statewide per discharge rate effective November 1, 2012.

h. The rate determined above is multiplied by the regular weight for that DRG to calculate the reimbursement for DRG claims.

- Effective for discharges occurring on or after October 1, 2013, 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 receive retrospective cost settlements that represent one-hundred percent (100%) 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 receive one-hundred percent (100%) of allowable SC Medicaid inpatient costs which includes base, capital, DME and IME costs.

- Effective for discharges incurred on or after October 1, 2013, SC large rural hospitals as defined by Rural/Urban Commuting Area classes with an average of 35 full time equivalent occupied beds or less based upon hospital fiscal year 2008 thru 2011 cost report census data will receive retrospective cost settlements that represent one-hundred percent (100%) of allowable SC Medicaid costs which include base, capital, DME and IME costs.

- Effective for discharges occurring on or after October 1, 2013, the retrospective cost settlement amount for qualifying hospitals with a burn intensive care unit will be limited to one-hundred percent (100%) of allowable SC Medicaid inpatient costs which includes base, capital, DME and IME costs.

- Effective for discharges occurring on or after July 1, 2014, hospitals that are eligible to receive retrospective cost reimbursement and fall under the 10th percentile will be eligible to receive Medicaid inpatient reimbursement in excess of cost subject to aggregate upper payment limitations. Conversely, hospitals that are eligible to receive retrospective cost reimbursement and are limited by the 75th percentile cap will be reimbursed the lower of allowable actual Medicaid reimbursable inpatient hospital costs or Medicaid inpatient hospital payments at the 75th percentile of the base rate component for discharges occurring on or after July 1, 2014.

Retrospective Hospital Cost Settlement Methodology For Qualifying Rural Hospitals and Qualifying Burn Intensive Care Unit Hospital:

The following methodology describes the inpatient hospital cost settlement process for qualifying hospitals effective for services provided on or after October 1, 2013.

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 worksheet D-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-3. 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-3 (ancillary). 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 above by Medicaid allowed charges. Medicaid allowed 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).

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 small hospital access payments, interim cost settlement payments, etc. The payment amount does not include payments authorized in Sections VI (N) or IV (O) of the State Plan. 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.

Effective for discharges occurring on or after July 1, 2014, hospitals that are eligible to receive retrospective cost reimbursement and fall under the 10th percentile will be eligible to receive Medicaid inpatient reimbursement in excess of cost subject to aggregate upper payment limitations. Conversely, hospitals that are eligible to receive retrospective cost reimbursement and are limited by the 75th percentile cap will be reimbursed the lower of allowable actual Medicaid reimbursable inpatient hospital costs or Medicaid inpatient hospital payments at the 75th percentile of the base rate component for discharges occurring on or after July 1, 2014.