DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Inlells	6-26-07

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 000799	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR _____ cc: Bowling ✓	[ ] Prepare reply for appropriate signature DATE DUE _____ [ ] FOIA DATE DUE _____ [X] Necessary Action

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
1.			
2.			
3.			
4.			

U.S. Department of Health and Human Services
Centers for Medicare and Medicaid Services
Finance, Systems and Budget Group (FSBG)
7500 Security Boulevard, Mail Stop S3-13-15
Baltimore, Maryland 21244
Fax # 410-786-1008

Fax Cover Sheet

Date: July 25, 2007

From: Mark Cobb for Stanley Fields Phone: _____

___ Finance, Systems and Budget Group
___ Survey and Administration Budget Staff
__/__ Division of Reimbursement & State Financing
___ Division of Financial Management
___ Division of State Systems
___ Division of Information Analysis & Technical Assistance
___ Division of National Systems
___ DATA Analysis Team

Log: K/Wells
c: Bowling
(Nec.act)

To: Robert Kerr, Director

Organization: Dept. of Health & Human Services

Phone: _____

Fax: 803-898-4515

Number of pages (including cover sheet): 3

Remarks: TN 06-19
approval letter + CF Form

CMS FAX FORM

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 and State Operations

RECEIVED
JUN 25 2007
Department of Health & Human Services
OFFICE OF THE DIRECTOR

Mr. Robert M. Kerr
Director
Department of Health and Human Services
P.O. Box 8206
Columbia, South Carolina 29202-8206

JUN 20 2007

Dear Mr. Kerr:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 06-19. This amendment modifies the State's payment methodology for setting payment rates for inpatient hospital services. Specifically, the amendment revises DSH qualification criteria and payment methodology, provides for retrospective cost settlements for services furnished by DSH hospitals and updates the swing bed and administrative day rates.

We conducted our review of your submittal according to the statutory requirements at sections 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 October 1, 2006. We are enclosing the CMS-179 and the amended approved plan pages.

Under regulations at 42 CFR 430.12(c)(i), States are required to amend State plans whenever necessary to implement changes in Federal law, regulations, policy interpretations, or court decisions. On May 25, 2007, CMS placed a final rule, CMS-2258-FC (Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership) on display at the Federal Register and that can be found at 72 Fed. Reg. 29748 (May 29, 2007) that would modify Medicaid reimbursement. Because of this regulation, some or all of the payments under this plan amendment may no longer be allowable expenditures for federal Medicaid matching funds. Public Law 110-28, enacted on May 25, 2007 instructed CMS to take no action to implement this final regulation for one year. CMS will abide by the time frames specified by the statute. Approval of the subject State plan amendment does not relieve the State of its responsibility to comply with changes in federal laws and regulations, and to ensure that claims for federal funding are consistent with all applicable requirements.

If you have any questions, please call Venesa Johnson at (410) 786-8281 or Stanley Fields at (502) 223-5332.

Sincerely

Bill Roerup

Dennis G. Smith
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 06-019

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, 2006

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: 69.54%

a. FFY 2007 $15,994 ($23 million x 69.54%)
b. FFY 2008 $ will reduce

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A, Pages 2, 3, 4, 6 through 12, 18, 21, 29, 31 through 35, 38, and 39

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-A, Pages 2, 3, 4, 6 through 12, 18, 21, 29, 31 through 35, 36, and 39

10. SUBJECT OF AMENDMENT:
Effective October 1, 2006, revisions to: (1) DSH qualification criteria, (2) DSH payment methodology, (3) hospitals eligible to receive inpatient cost settlements, (4) inpatient cost settlement payment methodology, (5) base year used to set DSH payments and interim Medicaid inpatient cost settlements, (6) updated swing bed and administrative day rates.

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

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Robert M. Kerr

13. TYPED NAME:
Robert M. Kerr

14. TITLE:
Director

15. DATE SUBMITTED:
December 20, 2006

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

FOR [illegible] USE ONLY

17. DATE RECEIVED

18. DATE APPROVED
6-25-07

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL

20. SIGNATURE OF REGIONAL OFFICIAL
[illegible] Regional Pvt. D.S.

21. TYPED NAME

22. TITLE

23. REMARKS

FORM HCFA-179 (07-92)

Ref: Log # 799

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 and State Operations

Mr. Robert M. Kerr
Director
Department of Health and Human Services
P.O. Box 8206
Columbia, South Carolina 29202-8206

JUN 20 2007

Dear Mr. Kerr:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 06-19. This amendment modifies the State's payment methodology for setting payment rates for inpatient hospital services. Specifically, the amendment revises DSH qualification criteria and payment methodology, provides for retrospective cost settlements for services furnished by DSH hospitals and updates the swing bed and administrative day rates.

We conducted our review of your submittal according to the statutory requirements at sections 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 October 1, 2006. We are enclosing the CMS-179 and the amended approved plan pages.

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Sincerely

Bill Roerwk

Dennis G. Smith
Director

RECEIVED
JUL 03 2007
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	1. TRANSMITTAL NUMBER: SC 06-019	2. STATE South Carolina
FOR: HEALTH CARE FINANCING ADMINISTRATION	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, 2006	

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:	7. FEDERAL BUDGET IMPACT: 69.54%
42 CFR, Subpart C	a. FFY 2007 $15,994 ($23 million x 69.54%) b. FFY 2008 $ will rebase
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-A, Pages 2, 3, 4, 6 through 12, 18, 21, 29, 31 through 35, 38, and 39	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Attachment 4.19-A, Pages 2, 3, 4, 6 through 12, 18, 21, 29, 31 through 35, 38, and 39

10. SUBJECT OF AMENDMENT:
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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. Kerr was designated by the Governor to review and approve all State Plans

12. SIGNATURE OF STATE AGENCY OFFICIAL:	16. RETURN TO:
13. TYPED NAME: Robert M. Kerr	South Carolina Department of Health and Human Services Post Office Box 8206 Columbia, SC 29202-8206
14. TITLE: Director	
15. DATE SUBMITTED: December 20, 2006	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:	18. DATE APPROVED: 6-20-07
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: OCT - 6 2006	20. SIGNATURE OF REGIONAL OFFICIAL: Bill Kearns FOR D.S.
21. TYPED NAME: William Lasowski	22. TITLE: Deputy Director, CMSO

23. REMARKS:

FORM HCFA-179 (07-92)

b. Retrospective inpatient cost settlements will be available to those hospitals identified under section VI, paragraph O of Attachment 4.19-A, pages 31 and 32.

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. 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. All inpatient services associated with admissions occurring on or after January 1, 1987, furnished by hospitals, are subject to the Hybrid prospective payment system. Special prospective payment system provisions are included for services provided by freestanding long-term care psychiatric hospitals.

4. Payment for all hospitals except those identified in 3 above will be made based on a Hybrid system which compensates hospitals either an amount per discharge (per case) for a diagnosis related group or a prospective per diem rate. DRG categories that are frequent, relatively homogeneous and considered by clinical experts not to be of a highly specialized nature will be paid an amount per discharge for each DRG category. DRG categories that are infrequent, highly variant and/or are considered by clinical experts to be of a highly specialized nature will be paid a hospital-specific per diem rate appropriate for the type of service rendered.

5. For discharges paid by the per case method under the Hybrid System, South Carolina specific relative weights and rates will be utilized. The DRG classification system to be used will be the classification system currently used by the Medicare program. The relative weights will be established based on a comparison of charges for each DRG category to charges for all categories. South Carolina's historical Medicaid claims database will be used to establish the DRG relative weights.

6. For discharges paid by the per diem method, an appropriate hospital-specific per diem rate will be established for the type of service.

The per diem rate will distinguish routine, special care, and neonatal intensive care days and will further distinguish these into surgery and non-surgery cases. Facilities will receive the appropriate per diem rate times the number of days of stay, subject to the limits defined in this plan.

7. An outlier set-aside adjustment (to cover outlier payments described in 10 of this section) will be made to the per discharge rates.

8. Payment for services provided in freestanding long-term care psychiatric facilities shall be based on the statewide average per diem for psychiatric long-term care. The base per diem rate will be the statewide total costs of these psychiatric services divided by total psychiatric days.

9. The prospective payments determined under both payment methods, the Hybrid prospective payment system for general acute care hospitals, distinct part units and short term care psychiatric hospitals and the per diem method for psychiatric long-term care facilities 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 O describes hospital cost settlements, Section VII describes Disproportionate Share Hospital payments, and Section X describes capital cost settlements.

   Effective October 1, 1999, South Carolina Department of Mental Health hospitals will be reimbursed 100% of their allowable Medicaid inpatient cost through a retrospective cost settlement process. For clarification purposes, settlements will be determined on a per patient day basis.

10. Special payment provisions, as provided in Section VI A of this plan, will be available under the Hybrid prospective payment system for discharges paid by DRG which are atypical in terms of patient length of stay or costs of services provided during the stay. These cases will be referred to as outliers. Special payment policies, as specified in Section VI C and D 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.

11. Reduced payment, as specified in Section VI B of this plan, will be made for cases paid on a per diem basis having stays exceeding two hundred percent of the hospital specific average length of stay.

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

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

14. Payment for services provided in psychiatric residential treatment facilities shall be an all-inclusive per diem rate. Section II paragraph 30 of this plan defines the costs covered by the all-

inclusive rate. Each facility's per diem rate will be calculated using base year data trended forward. Section V B describes the rate calculation.

15. Effective October 1, 1998, reimbursement for statewide pediatric telephone triage services will be available for the designated South Carolina Children's Hospitals. Payment will be based on the Medicaid portion of allowable service cost.

16. Effective October 1, 1999, a small hospital access payment will be paid to qualifying hospitals that provide access to care for Medicaid clients.

17. Effective October 1, 2000, hospitals participating in the SC Universal Newborn Hearing Screening, Detection, and Early Intervention Program will be reimbursed for Medicaid newborn hearing screenings. Effective July 1, 2001, all hospitals will be eligible for this reimbursement.

18. Effective for admissions on or after October 1, 2001, hospitals will be reimbursed for Norplant and Depo-Provera.

19. Effective for admissions on or after January 1, 2004 a standard co-payment amount of $25 per admission will be charged when a co-payment is applicable.

20. Effective for services provided on or after July 1, 2004, qualifying hospitals with burn intensive care units will receive annual retrospective cost settlements for the total cost of inpatient services provided to South Carolina Medicaid patients.

d. The patient leaves against medical advice.

e. In the case of a delivery, release of the mother and her baby will be considered two discharges for payment purposes. In case of multiple births, each baby will be considered a separate discharge.

f. A transfer from one hospital to another will be considered a discharge for billing purposes but will not be reimbursed as a full discharge except as specified in Section VI. Cases involving discharges from one unit and admission to another unit within the same hospital for the same period of hospitalization shall be recognized as one discharge for payment purposes. The DRG assignment for each case will be assigned based on services provided at the point of discharge.

12. Disproportionate Share Hospitals - South Carolina and border state's (Georgia and North Carolina) contracting acute care inpatient hospitals whose participation in the SC Medicaid Program and services to low income clients is disproportionate to the level of service rendered in other participating hospitals shall be considered disproportionate share.

Effective October 1, 2006, hospitals must satisfy one of the following criteria in order to qualify for the SC Medicaid DSH Program:

1. Be a licensed SC general acute care hospital that contracts with the SC Medicaid Program or;

2. Be a SC psychiatric hospital that is owned by the SC Department of Mental Health that contracts with the SC Medicaid Program or;

3. Be a general acute care border hospital (in North Carolina or Georgia) or any SC non-general acute care hospital that contracts with the SC Medicaid Program whose base year's Medicaid inpatient utilization rate is at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the State or whose base year's low-income utilization rate exceeds 25%.

In addition to the above criteria, hospitals must satisfy the next two criteria in order to qualify for the SC Medicaid DSH Program:

a. Hospitals must have a Medicaid day utilization percentage of at least one percent.

b. Hospitals must have at least two (2) obstetricians with staff privileges who have agreed to provide obstetrical services to Medicaid patients on a non-emergency basis. Staff privileges is defined as an obstetrician or other physician who is a Medicaid provider and is on the active staff of a hospital, who admits patients on a regular basis and routinely provides obstetric services at that hospital. This rule does not apply to a hospital that did not offer non-emergency obstetric services to the general population as of December 22, 1987.

Information will be collected at a point in time specified by the DHHS and will be used to determine which hospitals qualify for disproportionate share. Financial and statistical information used to determine disproportionate share qualification and payment will be submitted and/or verified on Medicaid supplemental worksheets. The supplemental worksheets must be completed correctly. Data will be verified by the DHHS using appropriate sources, including, but not limited to, the CMS 2552 and the DHHS inpatient MARS report and administrative days report. Disproportionate share eligibility does not qualify for the rate reconsideration process.

Disproportionate share payment will be based on a prospective payment system. The disproportionate share payment methodology is set forth is Section VII A.

13. General Acute Care Hospital - An institution licensed as a hospital by the applicable South Carolina licensing authority and certified for participation in the Medicare (Title XVIII) program.

14. Indirect Medical Education Cost - Those indirect costs resulting from the additional tests and procedures performed on patients because the hospital is a teaching institution. Such costs are determined using the number of interns and residents per operating bed in a Federally derived indirect medical education equation.

15. Indirect Medical Education Percentage - The percentage used to calculate indirect medical education cost. It is derived from the following formula:

$$1.43 \times (((1 + (\text{interns and residents})/\text{beds})^{.8795}) - 1)$$

16. Inpatient - A patient who has been admitted to a medical facility on the recommendation of a physician or a dentist and who is receiving room, board and professional services in the facility. A patient who is admitted to an acute care facility and expires while in the facility shall be considered an inpatient admission regardless of whether the stay was overnight.

17. Inpatient Services - Those items and services ordinarily furnished by a hospital for the care and treatment of patients. These items and services are provided under the direction of a licensed practitioner in accordance with hospital by-laws. Such inpatient services must be medically justified documented by the physician's records and must comply with the requirements of the state's designated Peer Review Organization (PRO). Emergency room services are included in the PPS inpatient rate only when a patient is admitted from the emergency room.

18. Intensive Technical Services - Those services rendered to patients having extreme medical conditions requiring total dependence on a life support system.

19. Long-Term Care Psychiatric Hospital - An institution licensed as a hospital by the applicable South Carolina licensing authority, certified for participation in Medicare XVIII program, primarily engaged in providing psychiatric services for the diagnosis and treatment of mentally ill persons with a Medicaid inpatient acute average length of stay greater than twenty-five (25) days.

20. Low Income Utilization Rate - The sum of fractions a and b.

    a. Numerator:

       Total Medicaid inpatient and outpatient charges, including charges for Medicaid managed care patients, plus cash subsidies for patient services received directly from state and local governments.

       Denominator:

       Total inpatient and outpatient charges (including cash subsidies) for patient services.

    b. Numerator:

       Total hospital charges for inpatient hospital services attributable to charity care less cash subsidies from "a" above.

       Denominator:

       Total inpatient charges for patient services.

       Cash subsidies are defined as monetary contributions or

donations received by a hospital. These contributions must originate from state and local governments. All contributions received will be considered as cash subsidies. If the funds are not designated for a specific type of service (i.e. inpatient services), they shall be prorated based on each type of service revenue to the hospital's total revenue (i.e. total inpatient revenues divided by total patient revenues).

Charity care is defined as care provided to individuals who have no source of payment, third party or personal resources. Total charges attributable to charity care shall not include contractual allowances and discounts or charges where any payment has been received for services rendered. An individual application, client specific, must be taken and a decision rendered in each applicant's case.

21. Medicaid Day Utilization Percentage - A facility's percent of hospital Medicaid inpatient acute days, including Medicaid managed care days, plus administrative days divided by total hospital inpatient acute days plus administrative days. The source of patient day information will be the filed CMS-2552 worksheet S-3, DHHS's MARS report, DHHS's administrative days report and requested supplemental worksheets.

22. Medically Necessary Services - Services which are necessary for the diagnosis, or treatment of disease, illness, or injury, and which meet accepted standards of medical practice. A medically necessary service must:

    a. Be appropriate to the illness or injury for which it is performed as to type and intensity of the service and setting of treatment;

    b. Provide essential and appropriate information when used for diagnostic purposes; and

    c. Provide additional essential and appropriate information when a diagnostic procedure is used with other such procedures.

23. Outliers - There are two kinds of outliers: day outliers and cost outliers. A day outlier occurs when the patient's length of stay exceeds a specified amount. A cost outlier occurs when a patient's charges exceed a specified amount. In both cases, the hospital will receive reimbursement for the outlier in addition to the base DRG payment. Outliers only apply to claims paid per discharge.

24. Outpatient - A patient who is receiving services at a hospital which does not admit him/her and which is not providing him/her with room and board services.

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

25. Pediatric Telephone Triage Services - Services provided by qualified medical personnel to assist callers in determining the nature of a child's medical problem and the appropriate action to take (e.g. see a physician the next day, go immediately to an emergency room, etc.). This service is available for parents or caretakers of SC Medicaid children 0 through 18 years old.

27. Principal Diagnosis - The diagnosis established after study to be chiefly responsible for causing the patient's admission to the hospital.

28. Psychiatric Distinct Part - A unit where psychiatric services are provided within a licensed and certified hospital. Patients in these units will be reimbursed through the Hybrid PPS.

29. Psychiatric Residential Treatment Facility - An institution primarily engaged in providing psychiatric services for the diagnosis and treatment of mentally ill persons who require less than hospital services. Medicare certification is not required. Effective April 1, 1994 in-state psychiatric residential treatment facilities are required to be licensed by DHEC in order to receive Medicaid reimbursement as described in State Plan 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.

30. Psychiatric Residential Treatment Facility All-Inclusive Rate - The all-inclusive rate will provide reimbursement for all treatment related to the psychiatric stay, psychiatric professional fees, and all drugs prescribed and dispensed to a client while residing in the Residential Treatment Facility.

31. 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 Hybrid PPS.

32. Small Hospital Access Payment - A payment for Medicaid participating

general acute care hospitals, located and licensed in South Carolina, with net patient revenue less than $70 million as reported on the 1997 Joint Annual Report.

33. Special Care Unit - A unit as defined in 42 CFR 413.53 (d).

34. Standard Deviation - The square root of the sum of the squares of the deviation from the mean in a frequency distribution.

35. Teaching Hospital - A licensed certified hospital currently operating an approved intern and resident teaching program.

III. Services Included in the Prospective Payment Rate

1. Acute Care Hospitals

The prospective payment rate will include all services provided in an acute inpatient setting except:

a. Professional component, including physician and CRNA services and any other professional fees excluded under Part A Medicare.

b. Ambulance, including neonatal intensive care transport.

2. Psychiatric Residential Treatment Facilities

The per diem reimbursement rate will be the "all-inclusive" rate as defined in Section II, paragraph 30 of this plan.

SC 06-019
EFFECTIVE DATE: 10/01/06
RO APPROVAL: JUN 26 2007
SUPERCEDES: MA 03-015

FY 1995-1996	6.0%
FY 1996-1997	0.0%
FY 1997-1998	4.0%
FY 1998-1999	0.0%
FY 1999-2000	15.0%
FY 2000-2001	1.0%
FY 2001-2002	7.0%
FY 2002-2003	0.0%
FY 2003-2007	0.0%

E. Medicaid Inpatient Discharges and Days

In the case of per discharge (also called per case) reimbursement, the number of Medicaid discharges for patients including nursery is required. In the case of per diem reimbursement, the number of Medicaid days is required. The sources for these data are described below.

1. The number of discharges for the hospital 1990 fiscal year will be the sum of the number reported on Worksheet S-3 (CMS-2552) as Medicaid discharges. These discharges are multiplied by the proportion of per case discharges to total 1990 claim discharges to get per case discharges.

2. The reported Medicaid inpatient days from Worksheet S-3 are multiplied by the proportion of per diem category days to total 1990 claim days to get per diem days.

3. The number of days for freestanding long-term care psychiatric hospitals will be the number on Worksheet S-3.

F. DRG Relative Weights

Relative weights used for calculating reimbursement for cases paid by discharge will be derived from South Carolina Medicaid hospital claim data. All claims, including those subsequently paid by per diem are included in the relative weight computation. The methodology used for computing relative weights utilizes claim charge data and is described below.

1. Hospital claims with admission dates on or after January 1, 1989 and paid as of April 30, 1993 are included in the computation and prepared as follows:

   a. Claims are edited to merge interim bills for the same discharge.

   b. Claims with lengths of stay greater than 200 days, patient ages less than zero and paid amounts less than or equal to zero are deleted.

   c. Claims containing information clinically inconsistent through application of the Medicare code editor software are deleted.

   d. DRGs are assigned to the claims using the CMS Grouper versions 6 and 10.

period. If applicable, add-ons will be inflated forward. The midpoint-to-midpoint inflation rates are as follows:

FY 1999-00	6.37%
FY 2000-01	11.43%
FY 2001-07	0.00%

Because audited cost reports are not available for the base year, desk audited cost report data will be used to set an interim rate. This interim rate will be effective until audited data is available. After an audit is performed, the interim rate may be adjusted to reflect audited allowable cost. If the rate is revised, all payments calculated with the interim rate will be adjusted to reflect payment with the final rate. See section X C 4 for retrospective cost settlement requirements.

F. Payment for Swing Bed Days

Acute care facilities will be reimbursed for qualifying skilled and intermediate care Medicaid patients in accordance with the daily rate schedule shown below.

October 1, 1997 - September 30, 1998	83.38
October 1, 1998 - September 30, 1999	86.69
October 1, 1999 - September 30, 2000	92.64
October 1, 2000 - September 30, 2002	96.85
October 1, 2002 - September 30, 2003	107.97
October 1, 2003 - September 30, 2004	116.13
October 1, 2004 - September 30, 2005	121.92
October 1, 2005 - September 30, 2006	129.16
October 1, 2006 -	136.24

This rate calculation is described in the Nursing Home State Plan Attachment 4.19-D. No rate increase is effective for services provided on or after October 1, 2001 through September 30, 2002.

G. Payment for Administrative Days

Acute care facilities will be reimbursed for Medicaid eligible skilled or intermediate patients who no longer require acute care and are waiting for nursing home placement. Administrative days must follow an acute inpatient hospital stay and will be covered in any hospital as long as a nursing home bed is not available. Reimbursement for administrative days is described below.

1. Each administrative day will be paid in accordance with the rate schedule shown below. This daily rate will be considered payment in full. There will be no cost settlement. This rate is a combination of the swing bed rate, as defined above, plus the Alternative Reimbursement Method (ARM) rate for pharmaceutical services.

October 1, 1997 - September 30, 1998	88.02 (ARM 4.64)
October 1, 1998 - September 30, 1999	91.79 (ARM 5.10)
October 1, 1999 - September 30, 2000	98.21 (ARM 5.57)
October 1, 2000 - September 30, 2002	103.85 (ARM 7.00)
October 1, 2002 - September 30, 2003	115.08 (ARM 7.11)
October 1, 2003 - September 30, 2004	123.57 (ARM 7.44)
October 1, 2004 - September 30, 2005	129.75 (ARM 7.83)
October 1, 2005 - September 30, 2006	136.99 (ARM 7.83)
October 1, 2006 -	144.07 (ARM 7.83)

2. Patients who require more intensive technical services (i.e. patients who have extreme medical conditions which require total dependence on a life support system) will be reimbursed using rates from the following schedule.

October 1, 2002 - September 30, 2003	180.00
October 1, 2003 - September 30, 2004	188.00
October 1, 2004 - September 30, 2005	197.00
October 1, 2005 - September 30, 2006	206.00
October 1, 2006 -	215.00

This rate was determined by cost analysis of:

a. A small rural S. C. hospital which was targeted to set up a ward to provide services for this level of care and

b. An out-of-state provider that has established a wing in a

2. When a rate has been set for a provider during a PPS rate period and the provider decides not to contract with the South Carolina Medicaid Program (SCMP) at anytime during that period, the facility will receive the set rate (with inflation applied if applicable).

3. Any provider approved to contract with the SCMP for which a facility-specific rate has not been calculated, will receive the statewide average rate. Facility-specific add-ons for Direct Medical Education, Indirect Medical Education and Capital may be calculated with the submission of information requested by the DHHS. The facility must send a written request in order for the DHHS to consider facility specific add-ons.

K. New Medicaid Providers

Prospective payment rates for established facilities which did not submit a South Carolina hospital-specific Medicaid cost report for the base year because the facility did not participate in the South Carolina Medicaid program at that time, will be determined as stated in I 1 a, b and c of this section.

L. Small Hospital Access Payments

Effective October 1, 1999, small hospital access payment adjustments will be paid to eligible hospitals in 4 quarterly installments throughout the year. In order to be eligible for this payment a hospital must meet the criteria defined in Section II 32 of this plan. The payment amount is equal to 13.5% of each qualifying hospital's total 1997 Medicaid revenue and will be allocated between inpatient and outpatient services.

M. Newborn Hearing Screening Payments

Effective October 1, 2000, qualifying hospitals (see Section I C 17) will be reimbursed for Medicaid newborn hearing screenings. Payment adjustments will be made to pay $26 for each inpatient newborn claim that includes the ICD-9 procedure code 95.41 (newborn hearing screening).

N. Depo-Provera and Norplant Payments

Effective for admissions on or after October 1, 2001, hospitals will be reimbursed for Norplant and Depo-Provera. Payment adjustments will be made to pay $371.00 for each inpatient delivery claim that includes the procedure code K0097 (Norplant) and $43.29 for each inpatient delivery claim that includes the procedure code J1055 (Depo-Provera).

O. Hospital Cost Settlements

Effective for services provided on or after October 1, 2006, 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 UPL/Cost Settlement methodology defined in Section VIII of this Attachment.

- 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.

- All SC psychiatric hospitals owned by the SC Department of Mental Health 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.

- All general acute care border hospitals (in North Carolina and Georgia) and SC non-general acute care hospitals contracting with the SC Medicaid Program that qualify for the SC Medicaid DSH Program will receive retrospective cost settlements that will represent sixty percent (60%) of each hospital's unreimbursed allowable SC Medicaid inpatient costs.

- All FY 2006 DSH qualifying out of state general acute care border hospitals (in North Carolina and Georgia) contracting with the SC Medicaid Program that no longer qualify for the FY 2007 SC Medicaid DSH Program will receive retrospective cost settlements that will represent sixty percent (60%) of each hospital's unreimbursed allowable SC Medicaid inpatient costs.

Effective for services provided on or after July 1, 2004, qualifying hospitals that employ a burn intensive care unit will receive an annual retrospective cost settlement for inpatient services provided to South Carolina Medicaid patients. The qualification criteria allowing hospitals to receive this cost settlement is listed in Section II 4 of this Attachment. In calculating these cost settlements, allowable cost and payments will be calculated in accordance with the public hospital 100% UPL methodology defined in Section VIII of this Attachment.

P. Graduate Medical Education Payments for Managed Care Patients

For clarification purposes, the SCDHHS will pay teaching hospitals for SC Medicaid graduate medical education (GME) cost associated with SC Medicaid managed care patients. The managed care GME payment will be calculated the same as the medical education payment calculated by the fee-for-service program. It will be based on quarterly inpatient claim reports submitted by the managed care provider and the direct and/or indirect medical education add-on amounts that are paid to each hospital through the fee-for-service program. Payments will be made to the hospitals on a quarterly basis or less frequently depending on claims volume and the submission of the required data on the claim reports.

Q. Co-Payment

Effective March 31, 2004, a standard co-payment amount of $25 per admission will be charged when a co-payment is applicable. The co-payment charged is in accordance with 42 CFR 447.53, 447.54(c) and 447.55. The inpatient cost settlement and disproportionate share hospital payment calculation will include uncollected Medicaid co-payment amounts in accordance with 42 CFR 447.57.

inflation method and the CMS Market Basket Indices described in 2 of this section. The inflated cost will be reduced by payments received from or for these SC uninsured patients.

New general acute care hospitals that open after December 31, 2003 but before October 1, 2005 will be eligible to receive DSH payments beginning October 1, 2005. The payments will be based on data from their initial cost report using the methodology stated above with appropriate trending.

b. The DSH UPL for SCDMH hospitals will be equal to 100% of the unreimbursed hospital cost for SC uninsured patients, but will be calculated as follows.

For FY 2007, each SCDMH hospital's FYE 2004 total allowable cost will be inflated from the base year to the payment period using the mid-year-to-mid-year inflation method and the CMS Market Basket Indices described in 2 of this section. The inflated cost will be divided by total acute care hospital days to get a cost per day amount. This cost per day amount will be multiplied by the uninsured acute care patient days to get uninsured patient cost. Any payments made by or for the uninsured patients will be subtracted from the inflated uninsured patient cost to arrive at the unreimbursed uninsured patient cost.

In the event the sum of the individual hospital DSH UPLs exceeds the federal allotment amount, the DSH UPL amount will be decreased proportionately to ensure the DSH payments are within the allotment amount. For FFY 2002-03 the reduction was made to the January through September period.

2. The following CMS Market Basket indices will be applied to the hospitals' FYE 2004 base year cost.

CY 2004	3.4%
CY 2005	3.3%
CY 2006	3.3%
CY 2007	3.1%

Inflation will be applied using the midpoint-to-midpoint inflation method. Costs will be inflated through the federal fiscal year.

3. In the event that CMS is unable to provide the final FFY DSH allotments in a timely manner, the SCDHHS reserves the right to use the most recently published CMS Market Basket indices if there is room for additional DSH payments between the DSH UPL and the final FFY DSH allotment for the applicable FFY.

4. All disproportionate share payments will be made by adjustments during the applicable time period.

B. Additional Requirements

Effective October 1, 2005, all qualifying DSH hospitals must adhere to the following rules for participation in the South Carolina Medicaid DSH Program.

1. Each hospital will be responsible for understanding the SC Medicaid DSH Program in order to provide the proper requested information required for DSH qualification and payment.

2. Each hospital agrees to participate in DSH data reviews conducted by SCDHHS and/or CMS, as well as audits of the DSH program data performed by an independent auditor hired by SCDHHS.

3. Each hospital agrees to be responsible for refunding SCDHHS if audit results determine that an overpayment has been made. All DSH payments are prospective. Only recoupments resulting from negative adjustments to data will be allowed.

R. Payment for Out of State Transplant Services

Payment for transplant services provided to South Carolina Medicaid recipients by out of state hospitals (i.e. other than the border hospitals of North Carolina and Georgia) will be based upon a negotiated price reached between the out of state provider and the Medical University Hospital Authority of South Carolina. The negotiated price will include both the professional and the hospital component. Transplant services provided to Medicaid recipients in South Carolina DSH hospitals will be reimbursed in accordance with the payment methodology outlined in Attachment 4.19-A and 4.19-B (i.e. a South Carolina general hospital will be reimbursed its allowable inpatient and outpatient costs in accordance with the Upper Payment Limit/Cost Settlement Methodology while the physician professional services will be reimbursed via the physician fee schedule).

VII. Disproportionate Share

A. Payments

Disproportionate share hospital (DSH) payments shall be made in accordance with the requirements of Section 1923 of the Social Security Act and the South Carolina state legislature. DSH payments will be paid to those facilities meeting the requirements specified in Section II 12.

1. Effective October 1, 2006, the DSH upper payment limits (UPL) will be set as follows:

   a. The DSH UPL for all SC general acute care hospitals that contract with the SC Medicaid Program will be equal to one hundred percent (100%) of the unreimbursed hospital cost for SC uninsured patients. The DSH UPL for all general acute care border hospitals (in North Carolina and Georgia) and SC non-general acute care hospitals contracting with the SC Medicaid Program will be equal to sixty percent (60%) of the unreimbursed hospital cost for SC uninsured patients. For clarification purposes, this includes SC patients participating in SC Medicaid capitated payment programs such as the HMO program and the PACE program.

      Except for the SC Department of Mental Health (SCDMH) hospitals, for FY 2007, each hospital's unreimbursed uninsured patient cost will be calculated as follows. Each hospital's allowable 2004 inpatient and outpatient uninsured patient charges will be multiplied by the hospital's FYE 2004 inpatient and outpatient cost-to-charge ratios to determine the base year cost. This cost will be inflated from the base year to the payment period using the mid-year-to-mid-year

VIII. 100% Upper Payment Limit (UPL)/Cost Settlement Methodology:

Effective for services on or after October 1, 2006, all qualifying DSH hospitals will receive retrospective SC Medicaid inpatient cost settlements. The following methodology describes the inpatient hospital cost settlement process for qualifying DSH hospitals:

A. Pending receipt of the cost report for the cost settlement period the base year cost report used for DSH payment purposes will be used to calculate an interim cost settlement. For FY 2007 the FYE 2004 cost report will be used. For SC general acute care hospitals, each hospital's interim cost settlement will be equal to 100% of a hospital's trended allowable base year cost minus payments adjusted for new Medicaid revenue since the base year. For all general acute care border hospitals (in North Carolina and Georgia) and SC non-general acute care hospitals, each hospital's interim cost settlement will be equal to 60% of a hospital's unreimbursed costs (i.e. trended allowable base year cost minus payments adjusted for new Medicaid revenue since the base year times 60%). New Medicaid revenue will include any base rate increases since FY 2004 plus inpatient payment adjustments paid in addition to the claims payments (e.g. small hospital access payments, trauma fund payments and Medicaid co-payments).

B. Trended allowable base year cost will be calculated using the following method. For FY 2007 each hospital's FYE 2004 Medicaid inpatient allowable charges will be multiplied by the hospital's FY 2004 cost-to-charge ratio to determine the base year cost. This cost will be inflated from the base year to the payment period using the mid-year-to-mid-year inflation method and the CMS Market Basket Indices as described in Section VII.A.2. S.C. general acute care hospitals will receive 100% of their allowable Medicaid inpatient cost settlement. General acute care border hospitals (in North Carolina and Georgia) and S.C. non-general acute care hospitals will receive 60% of their allowable unreimbursed Medicaid inpatient cost.

C. The interim cost settlement amount will be determined at the beginning of the federal fiscal year and the interim cost settlement adjustments will be paid quarterly throughout the year. Once the cost reports for the cost settlement period are received, desk audited cost settlements will be determined and processed.

Additionally, effective for services on or after October 1, 2006, all FY 2006 DSH qualifying out of state general acute care border hospitals (in North Carolina and Georgia) contracting with the SC Medicaid Program that no longer qualify for the FY 2007 SC Medicaid DSH Program will receive retrospective cost settlements that will allow them to receive sixty percent (60%) of each hospital's unreimbursed allowable SC Medicaid inpatient costs in accordance with the methodology described above.

b. Amended costs and statistics submitted within 30 days of the receipt of notification of rates.

C. Appeals

1. A provider may appeal the DHHS's decision on the rate reconsideration. The appeal should be filed in accordance with the procedural requirements of the South Carolina Administrative Procedures Act (SCAPA) and the DHHS's regulations.

2. A provider may appeal the Capital and/or Direct Medical Education Final Settlement. The appeal shall be filed in accordance with the procedural requirements of the SCAPA and the DHHS's regulations.

X. Review and Reporting Requirements

A. Utilization Review Specific to Prospective Payment

1. Utilization Review will be conducted by the state or its designee. Utilization review conducted by the designee will be performed as outlined in the current contract.

2. Negative review findings are subject to payment adjustment. Hospitals that develop or show trends in negative review findings will be subject to educational intervention.

B. Cost Report Requirements

Cost report requirements under the hospital prospective payment 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.

1. Acute Care Hospitals

a. All acute care hospitals contracting with the SC Medicaid program must submit the CMS-2552 cost report form within one hundred and fifty (150) days of the last day of their cost reporting period (or by the Medicare due date when an extension is granted by the Medicare program). Only hospitals with low utilization (less than 10 inpatient claims) will be exempt from this requirement.

b. Cost report data may be used for future rate setting, cost settlements, cost analysis and disproportionate share purposes. Effective October 1, 1999, SC Department of Mental Health hospital cost reports will be used for annual retrospective cost settlements.

[Effective for services provided on or after January 1, 2003, cost report data will be used to make retrospective inpatient cost settlements for public hospitals in accordance with the payment methodology in effect at January 1, 2003.]

Effective for services provided on or after October 1, 2003, cost report data will be used to make retrospective inpatient cost settlements for public and private (i.e. non-public) hospitals that qualify for the SC Medicaid DSH program in accordance with the payment methodologies in effect at October 1, 2003, October 1, 2004, October 1 2005 and October 1, 2006.

Effective for services provided on or after July 1, 2004, cost report data will be used to make annual retrospective inpatient cost settlements for qualifying hospitals that employ burn intensive care units.

Effective for services provided on or after October 1, 2006, cost report data will be used to make retrospective inpatient cost settlements for all FY 2006 DSH qualifying out of state general acute care border hospitals (in North Carolina and Georgia) contracting with the SC Medicaid Program that no longer qualify for the FY 2007 SC Medicaid DSH Program. This payment will be calculated in accordance with the methodology outlined in Section VIII of this Attachment.

c. Medicaid inpatient capital cost will be retrospectively settled. Capital cost will be settled at 100% of total allowable Medicaid inpatient capital cost for service dates on or after October 1, 2000. In accordance with OBRA 1993 requirements, the upper payment limit for disproportionate share hospitals is 100% of their allowable cost. DSH payments will be taken into account in the capital cost settlement process.

Effective for services on or after October 1, 2005, no additional cost settlement reimbursement will be provided for DSH hospitals for inpatient capital cost.

a. Administrative days and associated cost, charges and payments will be reported on a supplemental worksheet issued by the DHHS. These days, cost, charges and payments must remain separate from all other Medicaid reported data. There will be no settlement for administrative days.

2. Psychiatric Residential Treatment Facilities

All psychiatric residential treatment facilities will submit the CMS-2552 form as well as a certified audited financial statement. The CMS-2552 will be completed using each facility's fiscal year statistical and financial information. Each facility will be required to submit these documents within one hundred and fifty (150) days of the last day of their cost reporting period.