

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO: <u>Singleton</u>	DATE <u>2-21-12</u>
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DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER <u>101325</u>	<input type="checkbox"/> Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR <u>cc: Mr. Keck, Depo, CMS file</u>	<input type="checkbox"/> Prepare reply for appropriate signature DATE DUE _____
	<input type="checkbox"/> FOIA DATE DUE _____
	<input checked="" type="checkbox"/> 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.				

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



February 13, 2012

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

Re: South Carolina Title XIX State Plan Amendment, Transmittal #11-013

Dear Mr. Keck:

We have reviewed the proposed amendment to the South Carolina Medicaid State Plan SC 11-013 that was received in the Regional Office on July 14, 2011. This State plan amendment allows South Carolina Department of Health and Human Services (SCDHHS) to adjust payments downward for outpatient hospital services provided on or after July 11, 2011 in an effort to ensure that outpatient hospital expenditures remain within the budgeted funds for state fiscal year (SFY) 2012. These reductions are in addition to the update to the hospital multiplier taken on April 8, 2011.

Based on the information provided, we are now ready to approve the Medicaid State Plan Amendment SC 11-013. This SPA was approved on February 10, 2012. The effective date of this amendment is July 11, 2011. We are enclosing the approved form HCFA-179 and plan pages.

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

Sincerely,

A handwritten signature in cursive script that reads "Jackie Glaze".

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

Enclosures

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL**

1. TRANSMITTAL NUMBER:
SC 11-013

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
07/11/11

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

NEW STATE PLAN

AMENDMENT TO BE CONSIDERED AS NEW PLAN

AMENDMENT

6. FEDERAL STATUTE/REGULATION CITATION:
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (*Separate Transmittal for each amendment*)

7. FEDERAL BUDGET IMPACT: FMAP

a. FFY 2011 \$(1,100,000)
b. FFY 2012 \$(4,400,000)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
42 CFR Part 447 Subpart C

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

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

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

10. SUBJECT OF AMENDMENT:

Outpatient hospital payment reductions effective July 11, 2011

11. GOVERNOR'S REVIEW (*Check One*):

- GOVERNOR'S OFFICE REPORTED NO COMMENT
- COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
- NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

OTHER, AS SPECIFIED:
Mr. Keck was designated by the Governor to
review and approve all State Plans

12. SIGNATURE OF STATE AGENCY OFFICIAL:

Anthony E. Keck

16. RETURN TO:

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

13. TYPED NAME:
Anthony E. Keck

14. TITLE:
Director

15. DATE SUBMITTED:
July 12, 2011

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
07/14/11

18. DATE APPROVED:
02/10/12

19. EFFECTIVE DATE OF APPROVED MATERIAL:
PLAN APPROVED - ONE COPY ATTACHED

20. SIGNATURE OF REGIONAL OFFICIAL:
Jackie Glaze

21. TYPED NAME:
Jackie Glaze

22. TITLE:
Associate Regional Administrator
Division of Medicaid & Children Health Opts

23. REMARKS:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF SOUTH CAROLINA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE
(Reference Attachment 3.1-1-A)

2.a. OUTPATIENT HOSPITAL SERVICES

I. General Provisions

A. Outpatient Hospital Reimbursement and Upper Payment Limit (UPL) Provision

This plan establishes the methods and standards for reimbursement of outpatient hospital services effective October 1, 2007. Under this plan, a retrospective reimbursement system will be available for the following qualifying hospitals:

- Effective for services provided on or after July 11, 2011, all SC general acute care hospitals except those designated as SC critical access hospitals, SC isolated rural and small rural hospitals, certain SC large rural hospitals which must be located in a Health Professional Shortage Area (HPSA) for primary care for total population, and qualifying burn intensive care unit hospitals which contract with the SC Medicaid Program will receive retrospective cost settlements, that, when added to fee for service and non fee for service payments (i.e. interim estimated cost settlements paid via gross adjustments), will represent ninety-three percent (93%) of each hospital's allowable SC Medicaid outpatient costs which includes both base costs as well as all capital related costs except for the capital associated with Direct Medical Education (DME). The DME cost component of these SC general acute care hospitals with interns/residents and allied health alliance training programs will be retrospectively cost settled at eighty-seven.three percent (87.3%) of allowable SC Medicaid outpatient hospital DME costs (including the DME capital related costs).

- Effective for services provided on or after July 11, 2011, 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 continue to receive retrospective cost settlements that represent ninety-seven percent (97%) of allowable SC Medicaid outpatient costs which includes base, capital and DME 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 continue to receive ninety-seven percent (97%) of allowable SC Medicaid outpatient costs which includes base, capital and DME costs.

- All qualifying hospitals that employ a burn intensive care unit and contract with the SC Medicaid Program will receive an annual retrospective cost settlement for outpatient services provided to SC Medicaid patients. Effective for services provided on or after July 11, 2011, 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 outpatient costs which includes base, capital and DME costs.

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capital, and DME costs. In order for a hospital to qualify under this scenario, a hospital must:

- a. Be located in South Carolina or within 25 miles of the South Carolina border;
- b. Have a current contract with the South Carolina Medicaid Program; and
- c. Have at least 25 beds in its burn intensive care unit.

- All other hospitals that contract with the SC Medicaid Program for outpatient hospital services will receive prospective payment rates from the statewide outpatient hospital fee schedule. However, effective for services provided on or after July 11, 2011 by contracting out of state border hospitals that have SC Medicaid fee for service inpatient claims utilization of at least 200 claims, an annual analysis will be performed each cost reporting year to ensure that Medicaid reimbursement under the statewide outpatient hospital fee schedule does not exceed ninety-three percent (93%) of allowable SC Medicaid outpatient costs relating to base as well as all capital related costs except for the capital associated with DME. DME costs (including the capital related portion) 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. For outpatient hospital services provided by SC long term acute care hospitals beginning on or after July 11, 2011, an annual analysis will be performed each cost reporting year to ensure that Medicaid reimbursement under the statewide outpatient hospital fee schedule does not exceed ninety-three percent (93%) of allowable SC Medicaid outpatient costs relating to base as well as all capital related costs except for the capital associated with DME. The DME cost component of the SC long term acute care hospitals associated with interns/residents and allied health alliance training programs will be recognized at eighty-seven.three percent (87.3%) of allowable SC Medicaid outpatient hospital DME costs (including the DME capital related portion) in this analysis.

Determination of the Statewide Outpatient Hospital Fee Schedule Rates:

The October 1, 2007 statewide outpatient hospital fee schedule rates for acute care and long term acute care hospitals will be based upon the allowable outpatient cost information of covered services from each acute care hospital's FY 2005 cost report. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of outpatient hospital services. The agency's fee schedule rate was set as of October 1, 2007 and is effective for services provided on or after that date. All rates are published on the agency's website. All contracting SC acute care hospitals as well as out of state contracting border hospitals with SC Medicaid fee for service inpatient claims utilization of at least 200 claims were used in this analysis. The source document for Medicaid allowable outpatient costs will be the CMS-2512, which is the Medicare/Medicaid cost report. Allowable Medicaid outpatient costs will be determined in accordance with the Provider Reimbursement Manual Publication 15. However, for clarification purposes, one hundred

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percent (100%) of the South Carolina general acute care hospital provider tax will be considered an allowable Medicaid cost. Outpatient allowable costs, charges and statistics will be extracted from the cost report and prepared for the rate computations using the following general guidelines. The FY 2005 SCDHHS MARS paid claims summary data report for each acute care hospital identified above will also be used during the analysis.

- As filed total facility costs are identified from each facility's FY 2005 Worksheet B Part I (BI) CMS-2552 cost report. Total outpatient facility costs would include operating, capital, and direct medical education. CRNA costs identified under BI, column 20 are removed from allowable costs. Observation cost is reclassified.

- As filed total facility costs will be allocated to Medicaid outpatient hospital cost using the following method:

A cost-to-charge ratio for each ancillary service will be computed by dividing total costs as adjusted in this section by total charges as reported on Worksheet C. This cost-to-charge ratio will then be multiplied by SC Medicaid covered charges (as reported on Worksheet D Part V for Medicaid outpatient ancillary charges) to yield total SC Medicaid outpatient ancillary costs. The SC Medicaid outpatient cost-to-charge ratio will be determined by taking the sum of the SC Medicaid outpatient ancillary costs and dividing this amount by the sum of the SC Medicaid outpatient covered ancillary charges. The SC Medicaid outpatient cost-to-charge ratio will then be multiplied by the facility's SC Medicaid covered outpatient charges as identified on the SCDHHS MARS summary paid claims data report to determine each hospital's allowable SC Medicaid outpatient cost for FY 2005.

- The allowable Medicaid outpatient costs are summed to determine the aggregate Medicaid outpatient costs for FY 2005. An aggregate Medicaid allowable cost target was established at 95% of allowable Medicaid outpatient costs.
- After establishing the FY 2005 aggregate Medicaid allowable cost target, several actuarial models were developed and FY 2005 outpatient claims were repriced to determine the uniform increase in the statewide outpatient fee schedule rates. In order to trend the rates to the period October 1, 2007 through September 30, 2008, a 3.5% annual trend factor was applied. As a result of these steps, the statewide outpatient fee schedule rates increased by 135% effective October 1, 2007.

Determination of Hospital Specific Outpatient Multipliers:

In order to convert the statewide outpatient fee schedule rate payment into a hospital specific payment, an outpatient multiplier will be developed for each hospital. The outpatient multiplier will adjust the calculated statewide outpatient fee schedule claims payment to a hospital specific payment and will represent 100% of projected outpatient costs calculated in accordance with Agency defined criteria effective October 1, 2010. Hospitals that receive a hospital specific outpatient multiplier will be those eligible to receive retrospective cost settlements and those contracting out of state border hospitals that have S C Medicaid fee for service inpatient claims

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utilization of at least 200 claims. However, the outpatient multiplier for the contracting out of state border hospitals identified above will be set at an amount that will represent 70% of projected October 1, 2010 SC Medicaid outpatient hospital costs. Effective for services provided by contracting out of state border hospitals on or after July 11, 2011, projected allowable Medicaid outpatient hospital costs will be reduced to account for DME costs (including the capital related costs) no longer being reimbursed to contracting out of state border hospitals.

Effective for services provided on or after July 11, 2011, all SC general acute care hospitals except those designated as SC critical access hospitals. SC isolated rural and small rural hospitals, certain SC large rural hospitals located in a Health Professional Shortage Area (HPSA) for primary care for total population, and qualifying burn intensive care unit hospitals which contract with the SC Medicaid Program will have its hospital specific outpatient multiplier reduced to reflect ninety-three percent (93%) of the October 1, 2010 hospital specific outpatient multiplier. Additionally, the hospital specific multipliers of the SC general acute care hospitals identified above with interns/residents and allied health alliance training programs will be further adjusted to account for the allowance of eighty-seven.three percent (87.3%) of allowable SC Medicaid outpatient hospital DME costs (including the DME capital related costs).

Effective for services provided on or after July 11, 2011, all SC general acute care hospitals designated as SC critical access hospitals, SC isolated rural and small rural hospitals, certain SC large rural hospitals located in a Health Professional Shortage Area (HPSA) for primary care for total population, and qualifying burn intensive care unit hospitals which contract with the SC Medicaid Program will continue to receive ninety-seven percent (97%) of its October 1, 2010 hospital specific outpatient multiplier.

Effective for services provided on and after July 11, 2011, hospitals that do not qualify for retrospective cost settlements will receive an outpatient multiplier of .93.

The outpatient multiplier will be applied after the fee schedule payment has been calculated prior to any reduction for third party liability or coinsurance.

Clinical Lab Fee Schedule:

Effective October 1, 2010, all outpatient hospital clinical lab services provided by governmental and private hospitals will be reimbursed at one hundred percent (100%) of the 2010 Medicare Clinical Lab Fee Schedule rates for the State of South Carolina. Effective for services provided on or after July 11, 2011, all outpatient hospital clinical lab services except for those provided by hospitals identified as SC critical access hospitals, SC isolated rural and small rural hospitals, certain SC large rural hospitals located in a Health Professional Shortage Area (HPSA) for primary care for total population, or qualifying burn intensive care unit hospitals will be reimbursed at ninety percent (90%) of the 2010 Medicare Clinical Lab Fee Schedule rates for the state of South Carolina. SC critical access hospitals, SC isolated rural and small rural hospitals, certain SC large rural hospitals located in a Health Professional Shortage Area (HPSA) for primary care for total population, and qualifying burn intensive care unit hospitals will continue to be reimbursed at ninety-seven percent (97%) of the 2010 Medicare

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Clinical Lab Fee Schedule rates for the State of South Carolina. Therefore, the hospital specific outpatient multiplier described above will no longer be applied in the determination of outpatient hospital clinical lab services reimbursement.

Retrospective Hospital Cost Settlement Methodology:

The following methodology describes the outpatient hospital retrospective cost settlement process for qualifying hospitals. The source document for Medicaid allowable outpatient costs will be the CMS-2552, which is the Medicare/Medicaid cost report. Allowable Medicaid outpatient costs will be determined in accordance with the Provider Reimbursement Manual Publication 15. However, for clarification purposes, one hundred percent (100%) of the South Carolina General acute care hospital provider tax will be considered an allowable Medicaid costs. Effective October 1, 2010, outpatient hospital clinical lab services will no longer be retrospectively cost settled.

- A cost to charge ratio will be calculated for Medicaid outpatient claims. This ratio will be calculated using cost from worksheet B part I, charges from worksheet C, and Medicaid settlement data from worksheet D part V. For ancillary cost centers, a cost-to-charge ratio will be calculated by dividing cost as reported on worksheet B part I by total charges from worksheet C. Medicaid cost for each ancillary cost center will be determined by multiplying this ratio by Medicaid charges as reported on worksheet D part V. Charges not covered by the hospital payment system, such as CRNA and ambulance, must be excluded from this calculation. Effective for services provided on or after July 11, 2011, two cost to charge ratios will be determined for teaching hospitals. The first cost to charge ratio will be determined on base and all capital related costs except those associated with DME capital costs using the methodology previously described. The second cost to charge ratio will be determined using DME costs only (including the capital portion of DME costs) using the methodology previously described. The applicable reductions (i.e. 93% or 97% to base and capital and 0% or 87.3% to DME) will be applied to the calculated cost for each cost pool and an adjusted cost/charge ratio will be determined.
- Total allowable Medicaid cost will be determined at the time of cost settlement by multiplying the adjusted cost to charge ratio as calculated above, by Medicaid adjusted charges. Medicaid adjusted charges will be adjusted for non Mars Report adjustments such as claim refunds, third party recoveries, etc. This adjustment is calculated by multiplying the ratio of Mars Report covered charges to Mars Report covered payments by the sum of the non Mars Report adjustment amounts. This amount is subtracted (debit) or added (credit) as appropriate.
- The interim retrospective cost settlement amount will be determined by subtracting payments received from the allowable adjusted cost determined above. The payment amount includes Mars report payments and non Mars Report adjustments that were processed during the cost reporting/settlement period. Examples of these adjustments are refunds associated with third party payments, interim cost settlement payments, etc.

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Interim estimated cost settlements will only be allowed in extraordinary circumstances. It will be the responsibility of the provider to request and document the need for the interim cost settlement which could include the submission of one, or a combination of, the following documentation:

- a. a more current annual or a less than full year Medicare/Medicaid cost report;
- b. an updated outpatient cost-to-charge ratio;
- c. an analysis reflecting the financial impact of the reimbursement change effective for services provided on and after July 11, 2011.

The provider request will be reviewed by SCDHHS staff to determine if an interim settlement adjustment is justified based upon the best available information at the time.

For clarification purposes, all interim retrospective cost settlements will be subject to final audit. Any underpayment/(overpayment) identified as a result of the final audit will be paid or recouped accordingly.

Upper Payment Limits:

Outpatient hospital reimbursement shall be made in accordance with the upper payment limit requirements defined in 42 CFR 447.321.

Cost Report Requirements:

Cost report requirements under the prospective payment system and retrospective reimbursement system will conform to Medicare cost reporting principles and use as their basis the Medicare Cost Report Form - CMS-2552. In addition, providers must comply with Medicaid specific cost report requirements as published by the DHHS.

Audit Requirements:

All cost report financial and statistical information, the medical information contained on claims and information contained on supplemental worksheets such as the DSH survey, are subject to audit by the DHHS or its designee. The audited information will be used for future rate calculations, retrospective cost settlements, disproportionate share program requirements, utilization review contractor requirements and other analyses.

Co-payment Requirements:

Emergency services are not subject to co-payment. The outpatient cost settlement payment calculation will include uncollected Medicaid co-payment amounts in accordance with 42 CFR 447.57.

B.

Objectives

Implementation of the reimbursement methodology provided herein has the following objectives:

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b. Fees for non-surgical classifications are based on a relationship to the average historical payment made by the state of such procedures as determined from claim history data. ICD-9-CM diagnostic procedure codes which are not classified under the initial grouping of procedures will be assigned a class by the Commission. Professional medical personnel will be responsible for this function.

A procedure may be assigned to an existing classification or a new classification may be created to compensate for the procedure at the discretion of DHHS.

c. In the case of multiple diagnosis only one payment will be made. The class producing the highest rate of payment will be selected as the payment rate.

C. Treatment/Therapy/Testing Services

The methods and standards for payment of treatment/testing/therapy services are divided into two categories:

- Laboratory and Radiology
- Other Treatment, Therapy and Testing Services

1. Laboratory and Radiology

a. Services Included in Payment Amount

Payment for laboratory and radiology services rendered to outpatients shall consist of a fee for services. Effective October 1, 2010, all outpatient hospital clinical lab services will be reimbursed at one hundred percent (100%) of the 2010 Medicare Clinical Lab Fee Schedule rates for the State of South Carolina. Effective for services provided on or after July 11, 2011, all outpatient hospital clinical lab services except for those provided by hospitals identified as SC critical access hospitals, SC isolated rural and small rural hospitals, certain SC large rural hospitals located in a Health Professional Shortage Area (HPSA) for primary care for total population, or qualifying burn intensive care unit hospitals will be reimbursed at ninety percent (90%) of the 2010 Medicare Clinical Lab Fee Schedule rates for the state of South Carolina. SC critical access hospitals, SC isolated rural and small rural hospitals, certain SC large rural hospitals located in a Health Professional Shortage Area (HPSA) for primary care for total population, and qualifying burn intensive care unit hospitals will continue to be reimbursed at ninety-seven percent (97%) of the 2010 Medicare Clinical Lab Fee Schedule rates for the State of South Carolina, The fee excludes payment for services rendered directly to a patient by a physician (professional).

b. Payment Method

i. Payments for technical radiology and laboratory services shall be made based on the lesser of the charge or fixed fee for each CPT coded procedure.

2. Other Treatment, Therapy and Testing Services

a. Services Included In Payment Amount

Treatment, therapy, and testing services under this part include dialysis treatment, respiratory, physical, speech, occupational, audiological therapies, psychiatric treatment and testing. The payment for each treatment and testing category is a payment per service. Therapy services rendered under this part include the professional services component. If such services are provided in conjunction with surgical or non-surgical services, no separate payment shall be made.