DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Wells	4-2-07

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 000618	[X] Prepare reply for the Director's signature DATE DUE 4-9-07
2. DATE SIGNED BY DIRECTOR Cleared 4/4/07, letter attached. ✓	[ ] Prepare reply for appropriate signature DATE DUE _____ [ ] FOIA DATE DUE _____ [ ] 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.			

Log - Wells
"Rabby's Sign."

275 East Main Street
6W-A
Frankfort, KY 40621
Phone: (502) 223-5332 or 5927
Fax: (502) 223-2716

CMS

Fax

To:	Jeff Saxon	**From:**	Stanley Fields
Fax:	803-255-8228	**Pages:**	5
Phone:	803-898-1014	**Date:**	03/20/2007
Re:		**cc:**	

☐ **Urgent** X **For Review** ☐ **Please Comment** ☐ **Please Reply** ☐ **Please Recycle**

• **Comments:**

SC-06-019 RAI. Thanks.

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

March 20, 2007

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

RE: South Carolina 06-019

Dear Mr. Kerr:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 06-019. This amendment will revise and modify the payment method for hospital services by updating the base year used for disproportionate share hospital (DSH) qualification and calculation of DSH payments, revise DSH qualification criteria for instate and out of state hospitals, allow FY 2006 out of state border hospitals that no longer qualify for the FY 2007 DSH program to receive payment of inpatient cost settlements at 60% of unreimbursed Medicaid cost and update the swing bed and administrative day rates based on updated nursing facility rates. This amendment will also change the method for payment of inpatient hospital services to a retrospective method for hospitals that qualify for DSH payments.

We conducted our review of your submittal according to the statutory requirements at sections, 1902(a)(13), 1902(a)(30), 1923(g) and 1923(g)(1) of the Social Security Act and the regulations at 42 CFR 447 Subpart C. Before we can continue processing this amendment, we need additional or clarifying information.

The regulation at 42 CFR 447.252(b) requires that the State plan include a comprehensive description of the methods and standards used to set payment rates. Section 6002 of the State Medicaid Manual explains further that the State plan must be comprehensive enough to determine the required level of FFP and to allow interested parties to understand the rate setting process and the items and services that are paid through these rates. Further, since the plan is the basis for Federal financial participation, it is important that the plan's language be clear and unambiguous. Therefore, we have the following additional questions/concerns regarding TN 06-019.

1. In your response to the CMS funding question number 2 you indicated the South Carolina Department of Mental Health hospitals are reimbursed based on Certified Public Expenditures. Do the providers include out of state Title XIX days, charges and payments in the determination of cost and settlement of the annual cost reports?

2. Also in your response to funding question number 2 you included a projection of $1,392,956 to be paid by Medicaid for South Carolina Department of Corrections Hospital claims. Are these payments for incarcerated individuals?
3. Does the Department reconcile the annual payments for Medicaid and DSH to the cost settlements of providers actual cost for services provided to Medicaid recipients and uninsured patients?
4. Page 6, number 12. The plan language discusses the qualifications for out of state general acute hospitals and includes only North Carolina and Georgia by reference. Are Florida hospitals also eligible for DSH payments?
5. Page 12, III 1. Acute Care Hospitals. The prospective payment rate includes physicians cost including professional component and CRNA services and any other fees excluded under Part A Medicare. Does the State normal pay for these services on a fee for service schedule?
6. Page 18 E 1. & 2. Are these definitions still applicable? If yes, picase explain why this calculation is completed to determine Medicaid inpatient discharges and days. Do the Medicaid inpatient discharges and days reconcile to the states MMIS.
7. Page 32. What are fee for service and non-fee for service payments that will be included in the cost settlement?
8. Page 33, R. Trauma Hospital Payments. The Department has included language that states..."The funds will be disbursed annually if available". The language as written cannot be approved since cover services cannot be contingent upon availability of fund. Please revise this section to remove this contingency.
9. Page 35, VIII A. The reference to small hospital access payments, should that be small rural hospital access payments?
10. Page 35, VIII C. What is time period from a providers fiscal year end until a final settlement is completed?

Funding Questions.

We realize that the State submitted replies to the standard funding question. CMS, however, has subsequently updated and modified these questions. Please review and respond to following the revised questions. These questions are being asked and should be answered in relation to all payments made to all providers under Attachment 4.19-A of your State plan.

1. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by States for services under the approved State plan. Do providers receive and retain the total Medicaid expenditures claimed by the State (includes normal per diem, supplemental, enhanced payments, other) or is any portion of the payments returned to the State, local governmental entity, or any other intermediary organization?

   If providers are required to return any portion of payments, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount or percentage of payments that are

returned and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.)

2. Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state share of each type of Medicaid payment (normal per diem, supplemental, enhanced, other) is funded. Please describe whether the state share is from appropriations from the legislature to the Medicaid agency, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either an IGT or CPE. In this case, please identify the agency to which the funds are appropriated. Please provide an estimate of total expenditure and State share amounts for each type of Medicaid payment. If any of the non-federal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the state agency receives the transferred amounts from the local government entity transferring the funds. If CPEs are used, please describe the methodology used by the state to verify that the total expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b). For any payment funded by CPEs or IGTs, please provide the following:
   (i) a complete list of the names of entities transferring or certifying funds;
   (ii) the operational nature of the entity (state, county, city, other);
   (iii) the total amounts transferred or certified by each entity;
   (iv) clarify whether the certifying or transferring entity has general taxing authority; and,
   (v) whether the certifying or transferring entity received appropriations (identify level of appropriations).

3. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.

4. Please provide a detailed description of the methodology used by the state to estimate the upper payment limit (UPL) for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated). Please provide a current (i.e. applicable to the current rate year) UPL demonstration.

5. Does any governmental provider receive payments that in the aggregate (normal per diem, supplemental, enhanced, other) exceed their reasonable costs of providing services? If payments exceed the cost of services, do you recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?

We are requesting this additional/clarifying information under provisions of section 1915(f) of the Social Security Act (added by PL 97-35). This has the effect of stopping the 90-day clock for CMS to take action on the material. A new 90-day clock will not begin until we receive your response to this request.

Please submit your response to:

National Institutional Reimbursement Team
Attention: Mark Cooley
CMS, CMSO
7500 Security Boulevard, M/S S3-13-15
Baltimore, MD 21244-1850

If you have any questions or would like to discuss our comments and questions, please me at 502-223-5332 or Venesa Johnson at 410-786-8281.

Sincerely,

Stanley Fields
National Institutional Reimbursement Team
Centers for Medicare and Medicaid Services

Log 618

State of South Carolina
Department of Health and Human Services

Mark Sanford
Governor

Robert M. Kerr
Director

April 4, 2007

National Institutional Reimbursement Team
Attention: Mark Cooley
CMS, CMSO
7500 Security Boulevard, M/S S3-13-15
Baltimore, Maryland 21244-1850

RE: South Carolina Title XIX State Plan Amendment SC 06-019

Dear Mr. Cooley:

This is in response to Mr. Stanley Field's request for additional information dated March 20, 2007 related to the subject plan amendment. As part of our response, we are also enclosing an updated CMS 179 that reduces our original estimate due to our recent finalization of the interim Medicaid inpatient hospital cost settlements for FY 2007. Please note that CMS has previously approved the use of a retrospective cost settlement methodology for inpatient hospital services for qualifying DSH hospitals in earlier plan amendments.

CMS Question #1:

In your response to the CMS funding question number 2 you indicated the South Carolina Department of Mental Health hospitals are reimbursed based on Certified Public Expenditures. Do the providers include out of state Title XIX days, charges and payments in the determination of cost and settlement of the annual cost reports?

SCDHHS Response:

The South Carolina Department of Mental Health (SCDMH) hospitals file annual cost reports that provide the total cost incurred and the total patient days served by the hospital in providing services. As a result of our review of the SCDMH hospital cost reports, we determine an allowable cost per patient day which is then applied against South Carolina (SC) Medicaid patient days to determine the maximum SC Medicaid reimbursement for the cost reporting period. SC Medicaid patient days as well as SC Medicaid payments are generated from our MMIS system. Therefore, the South Carolina Department of Health and Human Services (SCDHHS) does not include any out of state Medicaid days in the SC Medicaid settlement computation.

Office of the Director
P.O. Box 8206 • Columbia, South Carolina 29202 -8206
(803) 898-2504 • Fax (803) 255-8235

CMS Question #2:

Also in your response to funding question number 2 you included a projection of $1,392,956 to be paid by Medicaid for South Carolina Department of Corrections Hospital claims. Are these payments for incarcerated individuals?

SCDHHS Response:

Yes – these expenditures are related to Medicaid eligible inmates that become a patient in a medical institution (e.g. inpatient hospital admission) and thus are not receiving care in a public institution. See HCFA Program Issuance Transmittal Notice, Region IV, dated March 6, 1998 for further information. The Program Identifier is MCD-05-98.

CMS Question #3:
Does the Department reconcile the annual payments for Medicaid and DSH to the cost settlements of providers actual cost for services provided to Medicaid recipients and uninsured patients?

SCDHHS Response:

The annual Medicaid inpatient payments are reconciled to one hundred percent (100%) of the allowable Medicaid inpatient cost associated with the provision of inpatient hospital services provided to SC Medicaid recipients in SC licensed general acute care DSH qualifying hospitals as well as qualifying hospitals with burn intensive care units (i.e. Doctor's Hospital of Augusta) during the provider's applicable cost reporting period. FY 2007 out of state DSH qualifying hospitals as well as out of state border hospitals that qualified for the SC Medicaid DSH Program during FY 2006 but no longer qualify for DSH during FY 2007 annual Medicaid inpatient payments are reconciled to sixty percent (60%) of the allowable unreimbursed Medicaid inpatient cost associated with the provision of inpatient hospital services provided to SC Medicaid recipients.

In regards to DSH payments, there is no annual reconciliation. Under our CMS approved DSH payment methodology, the SCDHHS determines prospective DSH payments using base year cost report data and uninsured data trended forward to the DSH payment period using CMS market based rates of inflation.

CMS Question #4:

Page 6, number 12. The plan language discusses the qualifications for out of state general acute hospitals and includes only North Carolina and Georgia by reference. Are Florida hospitals also eligible for DSH payments?

SCDHHS Response:

Under the plan proposal, only **border states** (i.e. North Carolina and Georgia) contracting acute care hospitals could be eligible to participate in the SC Medicaid DSH Program. Therefore, Florida hospitals would not be eligible to receive SC Medicaid DSH payments.

CMS Question #5:

Page 12, III 1. Acute Care Hospitals. The prospective payment rate includes physicians cost including professional component and CRNA services and any other fees excluded under Part A Medicare. Does the State normally pay for these services on a fee for service schedule?

SCDHHS Response:

To clarify, the prospective inpatient hospital payment rate **excludes** the professional_component, including physician and CRNA services and any other professional fees excluded under Part A Medicare. These services are reimbursed on a fee for service basis via our Medicaid fee schedule(s).

CMS Question #6:

Page 18 E 1. & 2. Are these definitions still applicable? If yes, please explain why this calculation is completed to determine Medicaid inpatient discharges and days. Do the Medicaid inpatient discharges and days reconcile to the states MMIS.

SCDHHS Response:

These definitions are still applicable and were used in the October 1, 1993 inpatient hospital rate rebasing effort. The Medicaid inpatient discharges and the Medicaid inpatient days that were calculated under this section were used in the calculation of the hospital specific add-ons (i.e. capital, direct medical education, and indirect medical education) that are added to the base DRG per discharge rate as well as the DRG per diem rate for each hospital. Each hospital's FY 1990 Medicaid inpatient days and discharge data that would have been used in the development of the October 1, 1993 rates would have been obtained through the Department's MMIS system and provided to the hospitals for use in the preparation of its FY 1990 cost report.

CMS Question #7:

Page 32. What are fee for service and non-fee for service payments that will be included in the cost settlement?

SCDHHS Response:

The fee for service payments that would be included in the determination of the cost settlement would include the prospective DRG per discharge and the prospective DRG per diem payments. The non-fee for service payments that would be included in the determination of the cost settlement would include those payments made by a "gross adjustment" that is not claim specific. Examples of these payments would include the small hospital access payments, trauma hospital payments, or any other lump sum adjustment paid to hospitals for the specific period.

CMS Question #8:

Page 33, R. Trauma Hospital Payments. The Department has included language that states..."The funds will be disbursed annually if available". The language as written cannot be approved since cover services cannot be contingent upon availability of fund. Please revise this section to remove this contingency.

SCDHHS Response:

As a result of the SFY 2005/2006 State Appropriations Act, the SCDHHS received new state funding that was designated to provide additional reimbursement for trauma hospitals as well as trauma specialists. The SCDHHS implemented the reimbursement policy applicable to the hospital portion of the trauma fund effective October 1, 2005 via our CMS approved state plan SC 05-009. Under our CMS approved reimbursement methodology, the state funds were matched with federal funds and the payments were made in accordance with the approved plan. Because we retrospectively cost settle allowable Medicaid inpatient costs of qualifying DSH hospitals as well as qualifying hospitals with burn intensive care units, these trauma payments were treated as Medicaid revenue and thus reduced the amount of the interim inpatient Medicaid cost settlement amount for FY 2006. Additionally, as reflected in the payment language, final retrospective cost settlements will be adjusted accordingly for any trauma fund payments received by trauma hospitals if the trauma hospital can provide documentation to support Medicaid inpatient trauma expenditures that had not been reimbursed via the retrospective Medicaid inpatient cost settlement of the hospital's FY 2006 cost report.

As a result of the SFY 2006/2007 State Appropriations Act, the SC General Assembly redirected the state funding from the SCDHHS to the SC Department of Health and Environmental Control (SCDHEC). At this time we have not been approached by the SCDHEC to continue the payment of the hospital portion of the trauma fund in accordance with our CMS approved reimbursement methodology. If this occurs, the SCDHEC will transfer the funding to the SCDHHS via an intergovernmental transfer (IGT). Therefore, in lieu of removing and inserting this language each year that the trauma payments will be made, we feel that it is appropriate to leave the reimbursement language in the plan with the conditional funding language as stated. Please remember that in the end the trauma hospital will receive retrospective Medicaid inpatient cost settlements as reflected in the state plan.

CMS Question #9:

Page 35, VIII A. The reference to small hospital access payments, should that be small rural hospital access payments?

SCDHHS Response:

No the reference is correct – it should remain as small hospital access payments (see section VI.L).

CMS Question #10:

Page 35, VIII C. What is time period from a providers fiscal year end until a final settlement is completed?

SCDHHS Response:

The SCDHHS implemented retrospective Medicaid inpatient hospital cost settlements effective January 1, 2003 for public DSH hospitals. The FY 2006 interim Medicaid inpatient cost settlements for qualifying DSH hospitals and qualifying hospitals with burn intensive care units were based on hospitals FY 2003 base year cost report and Medicaid payment information trended forward to FY 2006. During February 2007, the SCDHHS paid/recouped Medicaid funds that resulted from the actual retrospective cost settlement determined from the public DSH hospitals FY 2003 Medicaid cost reports.

In regards to the modified funding questions, the SCDHHS provides the following information:

CMS Funding Question #1:

Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved State Plan. Do providers receive and retain the total Medicaid expenditures claimed by the state (includes normal per diem, supplemental payments, enhanced payments, other) or is any portion of any payment returned to the State, local governmental entity, or any other intermediary organization? If providers are required to return any portion of payments, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.).

SCDHHS Response:

Under SC 06-019, hospitals retain 100% of the DRG, per diem, DSH, and supplemental payments (i.e., small hospital access payments and Medicaid inpatient hospital cost settlements) that will be reimbursed under this state plan amendment effective October 1, 2006. Residential Treatment Facilities (RTFs) retain 100% of the per diems and supplemental payments (i.e. retrospective cost settlements for state owned RTFs) that will be reimbursed under this state plan amendment.

CMS Funding Question #2:

Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state share of each type of Medicaid payment (normal per diem, supplemental, enhanced, other) is funded. Please describe whether the state share is from appropriations from the legislature to the Medicaid agency, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Please provide an estimate of total expenditures and state share amounts for each type of Medicaid payment. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either an IGT or CPE. In this case, please identify the agency to which the funds are appropriated. Please provide an estimate of total expenditure and State share amounts for each type of Medicaid payment. If any of the non-federal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the state agency receives the transferred amounts from the local government entity transferring the funds. If CPEs are used, please describe the methodology used by the state to verify that the total expenditures being

certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b). For any payment funded by CPEs or IGTs, pleased provide the following:

(i) a complete list of the names of entities transferring or certifying funds;

(ii) the operational nature of the entity (state, county, city, other);

(iii) the total amounts transferred or certified by each entity;

(iv) clarify whether the certifying or transferring entity has general taxing authority; and,

(v) whether the certifying or transferring entity received appropriations (identify level of appropriations).

SCDHHS Response:

Payment Method	Source of State Match
Inpatient Hospital DRG & Per Diem Payments	State Appropriations to the Medicaid Agency, Provider Taxes, and IGTs from SC Department of Corrections Which are State Appropriations
SCDMH Inpatient Hospital Payments	CPE Which is State Appropriations to SCDMH
IP Small Hospital Access Payments	State Appropriations to the Medicaid Agency and Provider Taxes
Swing Bed Hospitals - Per Diem Payments	State Appropriations to the Medicaid Agency and Provider Taxes
Administrative Days - Per Diem Payments	State Appropriations to the Medicaid Agency and Provider Taxes
Qualifying Hospitals Inpatient Cost Stlmts.	State Appropriations to the Medicaid Agency, Provider Taxes, and SCDMH CPE Which is State Appropriations
DSH Payments	State Appropriations to the Medicaid Agency, Provider Taxes, and SCDMH CPE Which is State Appropriations
SCDMH Hospitals & Private Psych Hospitals	CPE from SCDMH and State Agency IGTs for Private Pysch Hospitals Which are State Appropriations to SC State Agencies
Residential Treatment Facilities (RTFs) Per Diem Payments and Retrospective Cost Settlement Payments (For State Owned RTFs)	CPE from SCDMH for Their One RTF and State Agency IGTs for Private RTF Providers Which are State Appropriations to SC State Agencies. IGTs From a Non-State Owned Public General Acute Care Hospital.

State Agencies, via IGTs, transfer state appropriations for privately owned freestanding psychiatric hospital services, a limited number of privately owned general acute care hospital services, and privately owned residential treatment facility services. State agencies are required to transfer the state matching funds in advance, prior to the private entities identified above submitting their claims for Medicaid reimbursement. SCDMH certifies (CPEs) their match requirement for their IMD hospitals and their one RTF via the submission of annual provider cost reports. Additionally, the following contract language is included in the SCDMH contracts:

"SCDMH agrees to incur expenditures from state appropriated funds and/or funds derived from tax revenue in an amount at least equal to the non-federal share of the allowable, reasonable and necessary cost for the provision of services to be provided to Medicaid recipients under this contract prior to submitting claims for payment under this contract. Documentation of the non-federal expenditures necessary to support the claims for reimbursement must be maintained by SCDMH and are subject to audit by SCDHHS. SCDHHS may withhold and/or recoup reimbursements if Certified Public Expenditures are not adequately documented. As required by 45 CFR Part 201.5, all funds expended for the non-federal share of this contract must be in compliance with 42 CFR Part 433 Subpart B. Such non-federal funds must be actually expended for the provision of services to be provided under this contract."

A schedule detailing the information requested in items (i) through (v) is enclosed. Also, a schedule detailing an estimate of total expenditures and state share amounts for each type of Medicaid payment under SC 06-019 is enclosed.

CMS Funding Question #3:

Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.

SCDHHS Response:

Inpatient Small Hospital Access Payments	$ 7,086,914
Estimated Inpatient Non State Owned DSH Hospital Cost Settlements	*$209,915,361
Estimated SCDMH Hospital Cost Settlements	$ 1,000,000
Estimated SCDMH RTF Cost Settlement	$100,000

* - Reflects estimates of annual cost settlement amounts based upon DSH base year cost reports.

There are no enhanced payments made under the inpatient hospital services program, DSH program, or RTF program.

CMS Funding Question #4:

Please provide a detailed description of the methodology used by the state to estimate the upper payment limit for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated). Please provide a current (i.e. applicable to the current rate year) UPL demonstration.

SCDHHS Response:

The following methodology is used to estimate the upper payment limit applicable to inpatient hospital services for non - state owned public and privately owned or operated hospitals:

The base year cost report that is designated for DSH payment purposes is also used to estimate the upper payment limit. The SCDHHS determines the Medicaid cost for inpatient hospital services by applying the applicable cost reporting period's cost to charge ratio against covered Medicaid charges to determine allowable Medicaid inpatient cost. In order to trend the base year costs to the prospective payment period, CMS Market Basket inflation percentages are used. Once cost has been determined for the payment period, it is then compared to Medicaid revenues which would include the base year Medicaid revenue received plus an allocation of any rate increases/<decreases> occurring since the base year. Supplemental payments (i.e., adjustments paid outside of the claims payment process) applicable to the payment period are also included as a component of total Medicaid revenue paid. A comparison is then made between the trended base year cost and the adjusted Medicaid revenue to determine the amount of unreimbursed Medicaid inpatient cost for each hospital in the class. These amounts are then used to determine interim Medicaid inpatient cost settlements for qualifying hospitals as outlined in the state plan. To ensure that Medicaid inpatient payments do not exceed allowable Medicaid inpatient cost, retrospective cost settlements are performed on all qualifying non-state owned public and privately owned/operated hospitals in accordance with the state plan methodology.

A copy of the FY 2007 interim calculation described above is enclosed. State owned/operated hospitals receive retrospective cost settlements to ensure that Medicaid payments do not exceed allowable Medicaid costs.

CMS Funding Question #5:

Does any governmental provider receive payments that in the aggregate (normal per diem, supplemental, enhanced, other) exceed their reasonable costs of providing services? If payments exceed the cost of services, do you recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?

SCDHHS Response:

Governmental hospitals receive retrospective Medicaid inpatient cost settlements. In the event that a governmental hospital is overpaid as a result of our review of the provider's cost report in accordance with our state plan payment methodology, the SCDHHS will recoup the excess and return the Federal share of the excess to CMS. The same process is used for state owned RTFs as well.

If you should have any questions, please contact Mr. Jeff Saxon, Bureau of Reimbursement Methodology and Policy, at (803) 898-1040. Your timely review of this RAI will be greatly appreciated.

Sincerely,

Robert M. Kerr
Director

RMK/wsw
Enclosures