DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Singleton	3-8-12

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 10-0354	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR cc: Mr. Keck, Dep, CMS file, Chavis Cleared 8/7/12, letter attached.	[X] Prepare reply for appropriate signature DATE DUE 4-23-12
	[ ] 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.			

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
61 Forsyth Street, Suite 4T20
Atlanta, Georgia 30303

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

March 2, 2012

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

RE: State Plan Amendment (SPA) 11-026

Dear Mr. Keck:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 11-026. Effective October 1, 2011 this amendment proposes to revise the inpatient hospital reimbursement methodology for determining payment rates. Specifically, the following changes are being proposed: update the base year for determination of the disproportionate share hospital (DSH) payments to 2010 cost reports and calculate the interim DSH payments for 2012; update the inflation trend used to trend the DSH base year cost; reduce the out of state DSH limit qualifications from sixty percent to fifty percent of the hospital specific DSH limit; implement the All Patient Refined Diagnosis Related Grouper (APR-DRGs); update the cost outlier by using the hospital specific cost to charge ratio; and exempt large rural hospitals with 90 or fewer beds from the July 11, 2011 rate reductions.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a), 1902(a)(13), 1902(a)(30), 1903(a) and 1923 of the Social Security Act and the 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 Federal financial participation 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 FFP, it is important that the plan's language be clear and unambiguous. Therefore, we have the following additional questions/concerns regarding TN 11-026.

1. The CMS 179 indicates in item 7 that for 2012 and 2013 there will be an $8.25 million increase in FFP impact; however the public notice published by the Agency indicates a $21 million reduction in expenditures. Please provide an analysis of how the State determined the impact on the Federal Budget and an explanation of the differences.
2. The public notice indicates that the DSH payments to state owned long term care psychiatric hospitals will be reduced by five percent then later the description in the notice indicates they will be exempt from the reduction. Please explain which is correct.
3. Throughout the plan pages being amended different effective dates have been included. The CMS 179 indicates the effective date is October 1, 2011. Please correct the pages or the CMS 179 to include the correct effective date.
4. Page 2a-Rural Hospital exemption to rate reduction. This section exempts large rural hospitals as defined by Rural/Urban Commuting class with total licensed beds of 90 or less from the July 11, 2011 rate reduction. Please include a definition of the Rural/Urban Commuting class.
5. Page 3, item 8 Overview of Reimbursement Principles. This section describes adjustments that will be made to the DRG payments to recognize medical education, capital and ancillary services as appropriate. Please include clarifying language that describes the ancillary service adjustments that will be made.
6. Page 4, Section II, item 3 Definitions applicable to Inpatient Hospital Reimbursement. This section indicates the base year shall be each facility's fiscal year 2010. Should this be fiscal year 2010 cost report? This section also states "Cost reporting period and incurred inpatient hospital claims for the period July 1, 2010 through June 30, 2011 paid through August 5, 2011". It is not clear why you are including claims for what appears to be the cost report period 2011 in the base year 2010 cost reports. Please explain and add clarifying language.
7. Page 7, Section II, item 19 Complex Care Services. This section defines a long term care service for patients with a range of disabilities but does not describe or reference the sections that address the payment method. Please include a reference to the appropriate sections that describe the payment method for these services.
8. Page 10, Section IV, item A Per Discharge DRG List. This section indicates that a hospital specific and/or a statewide average per discharge rate will be established. Please include language that indicates when a hospital specific and statewide average per discharge will be utilized.
9. Page 14, Section D. This section has been revised to indicate the relative weights used for calculating reimbursement will be based on national relative weights versus using state specific weights. The following language appears to have been left in and should be deleted, "for cases paid by discharge will be derived from South Carolina."
10. Page 16, Section V.A.1. This section includes a discussion of how the per discharge rate will be calculated but does not include a step by step description of the method that will be used to calculate the per discharge rate by hospital or the determination of a state wide average per discharge rate. Please revise this section to describe the step by step process that will be used to determine the per discharge rates.

11. Page 22, section V.2. This section discusses the payment for outlier cases and indicates the payment may be made to providers for the cost beyond the threshold of the DRG payment. The language has to be specific as to when the payment will be made and the reference to "may" should be changed to shall or will be made.

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.

In accordance with our guidelines to all State Medicaid directors dated January 2, 2001, if we have not received the State's response to our request for additional information within 90 days from the date of this letter, we will initiate disapproval action on the amendment. In addition, because this amendment was submitted after January 2, 2001 and is effective after January 1, 2001, please be advised that we will continue to defer Federal financial participation FFP for State payments made in accordance with this amendment until it is approved. Upon approval, FFP will be available for the period beginning with the effective date through the date of approval.

Please submit your response to:

National Institutional Reimbursement Team
Attention: Mark Cooley
CMS, CMSO
7500 Security Boulevard, M/S S3-14-28
Baltimore, MD 21244-1850

If you have any questions or would like to discuss our comments and questions, please contact Stanley Fields at 502-223-5332.

Sincerely,

Jackie Glaze

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

Cc:

Venesa Day, CMCS
Mary Cieslicki, CMCS
Mark Cooley, CMCS
Stanley Fields, NIRT
Tim Weidler, NIRT
Davida Kimble, ROIV
Cheryl Wigfall, ROIV
Michelle White, ROIV
Mary Holly, ROIV

South Carolina Department of
Health & Human Services
Anthony E. Keck, Director
Nikki R. Haley, Governor

Log # 354

August 7, 2012

National Institutional Reimbursement Team
Attention: Mark Cooley
Centers for Medicare and Medicaid Services, CMSO
7500 Security Boulevard, M/S S3-14-28
Baltimore, Maryland 21244-1850

Re: Request for Additional Information on South Carolina Title XIX State Plan Amendment (SPA), Transmittal # SC 11-026

Dear Mr. Cooley:

The South Carolina Department of Health and Human Services (SCDHHS) is providing the following responses to the questions raised in Ms. Jackie Glaze's March 2, 2012 Request for Additional Information (RAI) regarding SPA SC 11-026. In addition to these responses, we are also enclosing revised plan language concerning the methodology which the agency will employ regarding the redistribution of DSH payments based upon the results of the 2012 Medicaid State Plan Rate Year DSH audit, which can be found on pages 33 and 33a. We are also enclosing a revised 179.

1. The CMS 179 indicates in item 7 that for 2012 and 2013 there will be an $8.25 million increase in FFP impact; however the public notice published by the agency indicates a $21 million reduction in expenditures. Please provide an analysis of how the State determined the impact on the Federal Budget and an explanation of the differences.

   SCDHHS Response:
   The CMS 179 estimate of $8.25 million FFP is composed of two items. First, SCDHHS projected a three percent increase ($12.5 million total/$8.8 million FFP) /in annual inpatient hospital fee for service costs relating to the October 1, 2011 through September 30, 2012 payment period resulting from SCDHHS's continued use of retrospective cost settlements at less than one hundred percent of allowable costs. Next, the three percent projected annual increase in inpatient hospital fee for service costs was reduced by a projected decrease (($.75) million total/ ($.53) million FFP) in DSH payments during the October 1, 2011 through September 30, 2012 DSH payment period. This resulted from the reduction to the hospital specific DSH limit (from 60% to 50%) for out of state border hospitals and SC non general acute care hospitals which qualified for the SC Medicaid DSH Program. However, please note that there was no offset reflected in the SC 11-026 CMS 179 to account for the final criteria that SCDHHS would use to further reduce DSH payments during the October 1, 2011 through September 30, 2012 DSH payment period, as this change to the DSH payment methodology and resulting payment reduction would have been reflected within SC 11-027.

Finally, the proposed public notice reflected an estimated annual total dollar payment reduction amount of $21 million which was solely attributable to the proposed DSH payment reductions that were to take place during the October 1, 2011 through September 30, 2012 DSH payment period. However, as a result of the finalization of the criteria used by SCDHHS to determine which hospitals would be subjected to a DSH payment reduction during the October 1, 2011 through September 30, 2012 DSH payment period and after numerous discussions with stakeholders, SCDHHS agreed to only reduce SC Medicaid DSH expenditures by an additional ($8.7) million total/ (6.1) million FFP during the October 1, 2011 through September 30, 2012 DSH payment period. This methodology change was submitted to CMS via SC 11-027.

2. The public notice indicates that the DSH payments to state owned long term care psychiatric hospitals will be reduced by five percent then later the description in the notice indicates they will be exempt from the reduction. Please explain which is correct.

   SCDHHS Response:
   It appears that CMS is referring to language reflected in the proposed public notice and misinterpreted language in item (5). Our initial proposal was to reduce the October 1, 2011 through September 30, 2012 DSH payment expenditures (net of the October 1, 2011 through September 30, 2012 DSH payments made to state owned long term care psych hospitals) by five percent. SCDHHS exempted the state owned long term care psych hospitals from any DSH payment reductions that are to be implemented during the October 1, 2011 through September 30, 2012 DSH payment period. Please note that the criteria used to determine which hospitals would be subjected to the October 1, 2011 through September 30, 2012 DSH payment reductions was submitted to CMS via SC 11-027.

3. Throughout the plan pages being amended different effective dates have been included. The CMS 179 indicates the effective date is October 1, 2011. Please correct the pages or the CMS 179 to include the correct effective date.

   SCDHHS Response:
   SCDHHS has resubmitted the entire 4.19-A package again to ensure that you have the appropriate pages, as we saw no error in our submitted file.

4. Page 2a-Rural Hospital exemption to rate reduction. This section exempts large rural hospitals as defined by Rural/Urban Commuting class with total licensed beds of 90 or less from the July 11, 2011 rate reduction. Please include a definition of the Rural/Urban Commuting class.

   SCDHHS Response:
   SCDHHS has included the definition of Rural Urban Commuting Area class under our Definitions section. See page 9, item # 31.

5. Page 3, item 8 Overview of Reimbursement Principles. This section describes adjustments that will be made to the DRG payments to recognize medical education, capital and ancillary services as appropriate. Please include clarifying language that describes the ancillary service adjustments that will be made.

   SCDHHS Response:
   SCDHHS has clarified the language which applies only to long-term care psychiatric hospitals See page 17, section 2.b. for further information.

6. Page 4, Section II, item 3 Definitions applicable to Inpatient Hospital Reimbursement. This section indicates the base year shall be each facility's fiscal year 2010. Should this be fiscal year 2010 cost report? This section also states "Cost reporting period and incurred inpatient hospital claims for the period July 1, 2010 through June 30, 2011 paid through August 5, 2011". It is not clear why you are including claims for what appears to be the cost report period 2011 in the base year 2010 cost reports. Please explain and add clarifying language.

   SCDHHS Response:
   The fiscal year 2010 cost reporting period is correct. In order to determine hospital specific per discharge rates effective October 1, 2011, SCDHHS established annual cost targets for each general acute care hospital eligible to receive a hospital specific per discharge rate. In the course of developing the hospital specific annual cost targets, two data sources were used – the hospital specific fiscal year 2010 inpatient hospital cost to charge ratio (adjusted for the April 8, 2011 and July 11, 2011 payment reductions) and the incurred inpatient hospital claims for the period July 1, 2010 through June 30, 2011 paid through August 5, 2011. Please see section V.A.1. on pages 15 and 16 that provides further detail/clarification language.

7. Page 7, Section II, item 19 Complex Care Services. This section defines a long term care service for patients with a range of disabilities but does not describe or reference the sections that address the payment method. Please include a reference to the appropriate sections that describe the payment method for these services.

   SCDHHSResponse:
   SCDHHS has included specific state plan reference language - see page 22.

8. Page 10, Section IV, item A Per Discharge DRG List. This section indicates that a hospital specific and/or a statewide average per discharge rate will be established. Please include language that indicates when a hospital specific and statewide average per discharge will be utilized.

   SCDHHS Response:
   SCDHHS has included the requested state plan language - see page 10.

9. Page 14, Section D. This section has been revised to indicate the relative weights used for calculating reimbursement will be based on national relative weights versus using state specific weights. The following language appears to have been left in and should be deleted, "for cases paid by discharge will be derived from South Carolina."

   SCDHHS Response:
   SCDHHS does not see the following language on page 14, Section D of its file "for cases paid by discharge will be derived from South Carolina." It has already been deleted according to our file. Please see the response to question #3.

10. Page 16, Section V.A.1. This section includes a discussion of how the per discharge rate will be calculated but does not include a step by step description of the method that will be used to calculate the per discharge rate by hospital or the determination of a state wide average per discharge rate. Please revise this section to describe the step by step process that will be used to determine the per discharge rates.

    SCDHHS Response:
    SCDHHS has provided the clarification language on page 16, section d. in reference to the hospital specific per discharge rate calculation. However, SCDHHS feels that section f. clearly explains the calculation of the statewide per discharge rate.

11. Page 22, section V.2. This section discusses the payment for outlier cases and indicates the payment may be made to providers for the cost beyond the threshold of the DRG payment. The language has to be specific as to when the payment will be made and the reference to "may" should be changed to shall or will be made.

    SCDHHS Response:
    According to our submitted files, SCDHHS has already corrected this language. Please see the response to question #3.

We look forward to CMS approval of SPA SC 11-026. If you have any questions or additional information is needed, please contact Mr. Jeff Saxon at (803) 898-1023 or Ms. Sheila Chavis at (803) 898-2707.

Sincerely,

Anthony E. Keck
Director

AEK/sc

Enclosures