DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Singleton/Chavis	2-20-16

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 000190	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR cc: Kost, Deps, CMS file Cleared 12/15/15, letter attached.	[ ] 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.			

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

CENTERS FOR MEDICARE & MEDICAID SERVICES

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

February 13, 2015

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

RE: State Plan Amendment (SPA) 14-019

Dear Mr. Soura:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid state plan submitted under transmittal number (TN) 14-019. Effective October 1, 2014 this amendment modifies the state's reimbursement methodology for setting payment rates for inpatient hospital services. Specifically, this amendment will make the following changes: increase base per discharge rates for acute care hospitals by 2.50%, continue the retrospective cost settlements for certain rural hospitals and burn units of hospitals, and update the swing bed and administrative day rates.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 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 (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 FFP, it is important that the plan's language be clear and unambiguous. Therefore, we have the following additional questions/concerns regarding TN 14-019:

General

1. The state estimates a federal budget impact of ($6,249,351) for FY 2015 and ($0) FY 2016. Please provide a detailed analysis showing how the state determined the federal budget impact.

2. Pending SPA SC 14-019 revises material that is currently pending in SPAs 12-024, 13-021, 13-023, 13-024 and 14-015. We cannot take action on SC 14-019 until all our concerns for the previous amendments are resolved. In addition, any changes made to the current pending SPAs should be included in SC 14-019.

Upper Payment Limit (UPL)

3. To comply with the requirements found on the Medicaid website at: http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/Accountability-Guidance.html, please provide an updated UPL with CMS requested revisions. The UPL demonstrations should include a comprehensive narrative description of the methodology (step by step) used to determine the UPL. The demonstration should also include a spreadsheet with provider specific information that starts with the source data and identifies the numerical result of each step of the UPL calculation. All source data should be clearly referenced (i.e., cost report year, W/S line, columns, and claims reports, etc.) in the demonstration.
4. Please provide an updated CMS Inpatient Hospital Guidance document from the Medicaid Website found at: http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/Accountability-Guidance.html.

Plan Pages

5. Page 1, Section I.C.1.b.
   This section indicates that free standing psychiatric rates for providers that contract with the Medicaid program for the first time or reenter the program will have rates established based on a state wide average. Please include a description of how the statewide average rate is established or reference the section in 4.19-A that provides this information.
6. Page 2, Section I.C.1.c.
   The last sentence in the section included two different effective dates for the base rates that are being increased by 2.50%. Please revise this section to clarify which provider groups are included in the October 1, 2013 base rate versus the July 1, 2014 base rate. Also, provide examples of the rate calculations for the providers with cost targets based on 97%, 93% and 87.3%.
7. Page 2, Section I.C.1.d.
   This section describes the South Carolina general acute care hospitals that will receive a 2.50% increase in their based rate. Included in this section is a description of the rural hospitals and critical access hospitals and all South Carolina hospitals located in a variety of locations throughout the state that are excluded from the rate increase. This section is very confusing and needs to be revised to make it clear where the definition of the criteria can be found in the state plan. As noted in 6 above please revise this section to clarify which provider group's base rate is being increased based on the October 1, 2013 base rate versus the July 1, 2014 base rate. This section also includes references to a 93% cost target and 87.3% for graduate medical education. Does the state complete an annual reconciliation of provider's cost to these cost targets and provide retrospective settlements to these amounts?
8. Page 2, Section I.C.1.e.
   This section describes the South Carolina defined rural hospitals including all critical access and hospitals located in a variety of locations throughout the state that are included for the rate increase. This section is very confusing and needs to be revised to make it clear where the definition of the criteria can be found in the state plan. As noted in 6 and 7 above please revise this section to clarify which provider group's base rate is being increased based on the October 1, 2013 base rate versus the July 1, 2014 base rate. This section also includes references to a 97% cost target. Does the state

complete an annual reconciliation of provider's cost to these cost targets and provide retrospective settlements to these amounts?

9. Page 23, Section I.
   This section includes a discussion of three different provider groups that will receive retrospective cost settlements with limitations based on July 1, 2014 normalization. Please provide an example of each one of these cost settlements with the application of the normalization action applied.

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 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: Stanley Fields
SPA_Waivers_Atlanta_R04@cms.hhs.gov

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

Log # 190

SOUTH CAROLINA
Healthy Connections
MEDICAID

Nikki R. Haley GOVERNOR
Christian L. Soura DIRECTOR
P.O. Box 8206 · Columbia, SC 29202
www.scdhhs.gov

December 15, 2015

Brenda,
This closes out
log # 000190

Ms. Jackie L. Glaze
Associate Regional Administrator
Center for Medicare and Medicaid Services
Division of Medicaid & Children's Health
Atlanta Regional Office
61 Forsyth Street, SW - Suite 4T20
Atlanta, Georgia 30303-8909

RE: Request for Additional Information (RAI) on Amendment (SPA), Transmittal # SC 14-019

Dear Ms. Glaze:

This is in response to your Request for Additional Informatic the above-referenced SPA. Please find below the South Services' (SCDHHS) responses to your questions.

GENERAL

1. The state estimates a federal budget impact of ($6,249,351) for FY 2015 and ($0) FY 2016. Please provide a detailed analysis showing how the state determined the federal budget impact.

   SCDHHS Response: The SCDHHS has enclosed an analysis which provides the requested information.

2. Pending SPA SC 14-019 revises material that is currently pending in SPAs 12-024, 13-021, 13-023, 13-024 and 14-015. We cannot take action on SC 14-019 until all our concerns for the previous amendments are resolved. In addition, any changes made to the current pending SPAs should be included in SC 14-019.

   SCDHHS Response: The SCDHHS has incorporated all changes from SPAs 12-024, 13-021, 13-023, 13-024 and 14-015 into this plan amendment.

Upper Payment Limit (UPL)

3. To comply with the requirements found on the Medicaid website at: http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/Accountability-Guidance.html, please provide an updated UPL with CMS requested revisions. The UPL demonstrations should include a comprehensive narrative description of the methodology (step by step) used to determine the UPL. The demonstration should also include a spreadsheet with provider specific information that starts with the source data and identifies the numerical result of each step of the UPL calculation. All source data should be clearly referenced (i.e., cost report year, W/S line, columns, and claims reports, etc.) in the demonstration.

   SCDHHS Response: The SCDHHS is enclosing its revised inpatient hospital UPL demonstration for FFY 2015 as requested.

4. Please provide an updated CMS Inpatient Hospital Guidance document from the Medicaid Website found at: http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/Accountability-Guidance.html.

   SCDHHS Response: The SCDHHS is enclosing the IP hospital UPL guidance document for FFY 2015 as requested.

Plan Pages

5. Page 1, Section I.C.1.b.
   This section indicates that free standing psychiatric rates for providers that contract with the Medicaid program for the first time or reenter the program will have rates established based on a state wide average. Please include a description of how the statewide average rate is established or reference the section in 4.19-A that provides this information.

   SCDHHS Response: The reimbursement methodology relating to the calculation of the statewide rate for free standing long term care psychiatric hospitals can be found on page 17, paragraph 2, section A.

6. Page 2, Section I.C.1.c.
   The last sentence in the section included two different effective dates for the base rates that are being increased by 2.50%. Please revise this section to clarify which provider groups are included in the October 1, 2013 base rate versus the July 1, 2014 base rate. Also, provide examples of the rate calculations for the providers with cost targets based on 97%, 93% and 87.3%.

   SCDHHS Response: The SCDHHS is enclosing a revised page 2 in order to clarify this concern. Please remember that this section of the plan amendment allows for a 2.50% increase to the base rate component of the qualifying out of state border hospitals effective for discharges incurred on and after October 1, 2014. This 2.50% increase is applied to the base rate component of those hospitals that were subject to the July 1, 2014 rate normalization adjustment (i.e. the hospital's July 1, 2014 per discharge rate) as well as those hospitals that were not subject to the July 1, 2014 rate normalization adjustment (i.e. the hospital's October 1, 2013 per discharge rate). Most inpatient hospital rates were not impacted by the July 1, 2014 rate normalization adjustment. We have also enclosed copies of the requested rate sheets for your review.

7. Page 2, Section I.C.1.d.
   This section describes the South Carolina general acute care hospitals that will receive a 2.50% increase in their base rate. Included in this section is a description of the rural hospitals and critical access hospitals and all South Carolina hospitals located in a variety of locations throughout the state that are excluded from the rate increase. This section is very confusing and needs to be revised to make it clear where the definition of the criteria can be found in the state plan. As noted in 6 above please revise this section to clarify which provider group's base rate is being increased based on the October 1, 2013 base rate versus the July 1, 2014 base rate. This section also includes references to 93% cost target and 87.3% for graduate medical education. Does the state complete an annual reconciliation of provider's cost to these cost targets and provide retrospective settlements to these amounts?

   SCDHHS Response: The SCDHHS is enclosing a revised page 2 in order to clarify this concern. Please remember that this section of the plan amendment allows for a 2.50% increase to the base rate component of all of the SC general acute care hospitals that have not been deemed as a SC Medicaid defined rural hospital effective for discharges incurred on and after October 1, 2014. This 2.50% increase is applied to the base rate component of those hospitals that were subject to the July 1, 2014 rate normalization adjustment (i.e. the

hospital's July 1, 2014 per discharge rate) as well as those hospitals that were not subject to the July 1, 2014 rate normalization adjustment (i.e. the hospital's October 1, 2013 per discharge rate). Most inpatient hospital rates were not impacted by the July 1, 2014 rate normalization adjustment. The SCDHHS does not provide for retrospective cost settlements for this class of hospitals as well as those identified in Section I.C.1.c.

8. Page 2, Section I.C.1.e.
   This section describes the South Carolina defined rural hospitals including all critical access and hospitals located in a variety of locations throughout the state that are included for the rate increase. This section is very confusing and needs to be revised to make it clear where the definition of the criteria can be found in the state plan. As noted in 6 and 7 above please revise this section to clarify which provider group's base rate is being increased on the October 1, 2013 base rate versus the July 1, 2014 base rate. This section also includes references to a 97% cost target. Does the state complete an annual reconciliation of provider's cost to these cost targets and provide retrospective settlements to these amounts?

   SCDHHS Response: The SCDHHS is enclosing a revised page 2 in order to clarify this concern. Please remember that this section of the plan amendment allows for a 2.50% increase to the base rate component of the interim payment rate for all of the SC general acute care hospitals that have been deemed as a SC Medicaid defined rural hospital effective for discharges incurred on and after October 1, 2014. This 2.50% increase is applied to the base rate component of those hospitals that were subject to the July 1, 2014 rate normalization adjustment (i.e. the hospital's July 1, 2014 per discharge rate) as well as those hospitals that were not subject to the July 1, 2014 rate normalization adjustment (i.e. the hospital's October 1, 2013 per discharge rate). Most inpatient hospital rates were not impacted by the July 1, 2014 rate normalization adjustment. The SCDHHS does provide for retrospective cost settlements for SC defined rural hospitals and qualifying burn intensive care unit hospitals at 100% of allowable Medicaid reimbursable inpatient hospital costs.

9. Page 23, Section I.
   This section includes a discussion of three different provider groups that will receive retrospective cost settlements with limitations based on July 1, 2014 normalization. Please provide an example of each one of these cost settlements with the application of the normalization action applied.

   SCDHHS Response: The SCDHHS is enclosing a revised page 23 in order to clarify this concern. To summarize, if you are a hospital eligible to receive retrospective cost settlements and were capped by the 75th percentile, you would be reimbursed the lower of allowable Medicaid reimbursable costs or the actual Medicaid payments received for discharges incurred on and after July 1, 2014. On the other hand if you are a hospital eligible to receive retrospective cost settlements and your rate was increased to the 10th percentile base rate component, you would be reimbursed the greater of allowable Medicaid reimbursable costs of the actual Medicaid payments received for discharges incurred on and after July 1, 2014.

If additional information is needed of if you have questions, please contact Jeff Saxon at (803) 898-1023 or Sheila Chavis at (803) 898-2707.

Sincerely,

Christian L. Soura
Director

CLS/dsrc