VIII. Changes to the Prospective Payment Rates

A. Future Redetermination of Prospective Payment Rates

1. In future years, prospective payment rates for acute care facilities will be established by trending forward the base year prospective payment rates by applying an inflation factor, as defined in Section IV, for the prospective payment year.

2. The outlier set-aside, as described in Section IV of this plan may be recalculated periodically.

3. The DHHS will recalculate the base year prospective payment rates as the agency deems necessary. Recalculation of the base year may involve recalibration of the relative weights, use of a more recent cost report base year or both.

4. The DHHS may recalculate the psychiatric residential treatment facility per diem rate each year based on a prior year's cost report data.

B. Rate Reconsideration

1. Providers will have the right to request a rate reconsideration if one of the following conditions has occurred since the base year:

   a. Changes in case-mix since the base year. Such requests will be accompanied by documentation of the case-mix change using DRG case-mix index and severity of illness measures. Use of the DRG case-mix index alone is not satisfactory for rate reconsideration under this part. The severity of illness study may be based on a statistically valid random sample of Medicaid patients treated in the facility on an annual basis. If a sample is used, the sampling methodology including the standard error value will be included in the documentation.

   b. An error in the facility's rate calculation. Such request will include a clear explanation of the error and documentation of the desired correction.

   c. Extraordinary circumstances, such as acts of God, occurring since the base year and as defined by the DHHS. Such requests will be submitted along with documentation which clearly explains the circumstance, demonstration that the circumstance was extraordinary and unique to that facility, and the expenses associated with the circumstance.

2. Rate reconsideration will not be available for the following:

   a. The payment methodology, case-mix adjustment, relative weights, inflation indices, DRG classification system.

   b. Inflation of cost since the base year.

c. Increases in salary, wages, and fringe benefits.

3. Requests for rate reconsideration will be filed in accordance with procedures described in the Rate Reconsideration Manual which can be obtained upon request, from the Division of Acute Care Reimbursement. Rate reconsideration requests will be submitted in writing to the DHHS and will set forth the reasons for the requests. Each request will be accompanied by sufficient documentation to enable the DHHS to act upon the request. Rate reconsiderations for errors in the facility's rate will be submitted in writing within 30 days of the rate notification.

4. The request will be forwarded for review to the Division of Acute Care Reimbursement. This Division will review all requests for rate reconsideration and will issue a decision in writing to the provider.

5. The provider will be notified of the DHHS's decision within 90 days of receipt of the completed requested.

6. Pending the DHHS's decision on a request for rate reconsideration, the facility will be paid the prospective payment rate currently in effect, as determined by the DHHS. If the reconsideration request is granted, the resulting new prospective payment rate will be effective the later date of:

   a. The receipt of the request and supporting documentation requested by panel; or

   b. The first date of the prospective rate year, should the rate reconsideration be granted before this date; or

   c. The date on which the asset leading to the expenditure was placed into service.

7. In no case will a rate reconsideration revision be granted if it will result in a facility's reimbursement exceeding what would have been paid under Medicare principles of reimbursement.

8. Rate reconsiderations granted under this section will be effective for the remainder of the prospective rate year. Requests and documentation will be kept in a facility file and may be automatically reviewed in the following year if the panel has determined that the condition will continue to exist. The facility will be asked in future years to supply only necessary updated information.

9. Psychiatric residential treatment facilities may request a rate reconsideration within 30 days of receiving their rates. The rate reconsideration may be filed for the following circumstances:

   a. An error in the facility's rate calculation.

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

C. Appeals

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

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

IX. Review and Reporting Requirements

A. Utilization Review Specific to Prospective Payment

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

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

B. Cost Report Requirements

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

1. Acute Care Hospitals

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

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

c. Medicaid inpatient capital cost will be retrospectively settled. The capital cost settlement will be 85% of total allowed Medicaid inpatient capital cost effective for cost reporting periods ending on and after September 30, 1989. Effective 7/1/89 reimbursement for Medicaid inpatient Direct Medical Education cost will also be retrospectively settled. In accordance with OBRA 1993 requirements, disproportionate share hospitals will not be eligible for cost settlements since they will receive payment for 100% of their unreimbursed SC Medicaid cost through the SC DSH program.

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

(Deemed Approved)

2. Psychiatric Residential Treatment Facilities

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

C. Audit Requirements

All cost report financial and statistical information as well as the medical information contained on claims, is subject to audit by the DHHS or its designee. The audited information may be used for future rate calculations, inpatient capital and direct medical education cost settlements, disproportionate share program requirements, utilization review contractor requirements and other analyses.

1. Cost reports of non-disproportionate share hospitals will be desk-audited in order to calculate capital cost settlements. Capital cost settlements will be 85% of total allowable Medicaid inpatient capital cost and may be processed within 2 years after the end of a hospital's cost report period.

2. Supplemental worksheets submitted by hospitals qualifying for disproportionate share payments will be reviewed for accuracy. No additional payments will be made as a result of these reviews. Adjustments will be made only when reviews uncover overpayments or result in loss of disproportionate share status.

3. Medical audits will focus on the validity of diagnosis and procedure coding for reconciliation of appropriate expenditures made by the DHHS as described in A of this section.

4. Retrospective cost settlements will apply to RTFs as follows:

   a. There will be no retrospective cost settlement for psychiatric RTFs when audited base year cost data is used to set the reimbursement rate.

   b. There will be a retrospective cost adjustment for psychiatric RTFs when an interim rate is set on unaudited base year cost data. If the interim rate includes subsequent period add-ons, a retrospective cost adjustment will be performed on this subsequent period cost. Only recoupments resulting from negative adjustments will be allowed.

   c. There will be a retrospective cost settlement for state owned and operated psychiatric RTFs. These will be settled at 100% of allowable cost.

   d. There will be no retrospective cost adjustment for RTFs who are paid the statewide average rate.

The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.