DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop 52-26-12
Baltimore, Maryland 21244-1850

Center for Medicaid and State Operations (CMSO)

MAR 15 2010

Ms. Emma Forkner
Director
Department of Health and Human Services
P.O. Box 8206
Columbia, South Carolina 29202-8206

RE: SPA SC 09-012

Dear Ms. Forkner:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 09-012. Effective October 1, 2009, this amendment modifies the State's reimbursement methodology for setting payment rates for inpatient hospital services. Specifically, the amendment will update the base year cost reports used to determine DSH eligibility and DSH payments, update the market basket index used to increase provider rates, and increase hospital payment rates.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(13), 1902(a)(30), 1903(a) and 1923 of the Social Security Act and the implementing Federal regulations at 42 CFR Part 447. We have found that the proposed changes in payment methodology comply with applicable requirements and therefore have approved them with an effective date of October 1, 2009. We are enclosing the CMS-179 and the amended approved plan pages.

If you have any questions, please call Stanley Fields at (502) 223-5332 or Venesa Day at 410-786-8281.

Sincerely

//s//
Cindy Mann
Director, CMSO

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: SC 09-012

2. STATE: South Carolina

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
October 1, 2009

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

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR, Subpart C

7. FEDERAL BUDGET IMPACT:

a. FFY 2010 $46.4 Million
b. FFY 2011 Rates + DSH will be updated

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-A, pages 4, 7, 11, 13, 16, 17, 18, 24, 27 through 28a and 32

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Attachment 4.19-A, pages 4, 7, 11, 13, 16, 17, 18, 24, 27 through 28a and 32

10. SUBJECT OF AMENDMENT:
Effective October 1, 2009,annual updates to: (1) October 1, 2009 inpatient rates/multipliers; (2) FFY 2010 DSH Allotment; (3) Base Year Cost/Data Reports used for FY 2010 DSH; and (4) update to cost components for each hospital's specific DSH limit.

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:
Ms. Forkner was designated by the Governor to review and approve all State Plans

12. SIGNATURE OF STATE AGENCY OFFICIAL:
//s//

13. TYPED NAME:
Emma Forkner

14. TITLE: Director

15. DATE SUBMITTED: 12-18-09

16. RETURN TO:
South Carolina Department of Health and Human Services
Post Office Box 8206
Columbia, SC 29202-8206

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
12-18-09

18. DATE APPROVED: 03-15-10

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
10-01-09

20. SIGNATURE OF REGIONAL OFFICIAL:
//s//

21. TYPED NAME:
Cindy Mann

22. TITLE: Director, CMSO

23. REMARKS:

inpatient services provided to South Carolina Medicaid patients.

II. Definitions Applicable to Inpatient Hospital and Residential Treatment Facility Reimbursement

The following definitions will help in understanding the payment rates set for inpatient hospital and residential treatment facility services:

1. Administrative Days - The days of service provided to recipients who no longer require acute hospital care, but are in need of nursing home placement that is not available at the time. The patient must meet either intermediate or skilled level of care criteria.

2. Arithmetic Mean (average) - The product of dividing a sum by the number of its observations.

3. Base Year - The fiscal year used for calculation of payment rates. For the hybrid payment system rates effective on and after October 1, 2009, the base year shall be each facility's 2006 fiscal year. For the freestanding long-term psychiatric hospital rates, the base year shall be each facility's 1990 fiscal year.

4. Burn Intensive Care Unit Cost Settlement Criteria - In order to qualify for this cost settlement a hospital must satisfy all of the following criteria. A hospital must:

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

5. Capital - Cost associated with the capital costs of the facility. Capital costs include, but are not limited to, depreciation, interest, property taxes, property insurance, and directly assigned departmental capital lease costs. In no case shall the capital amount include amounts reflecting revaluation of assets due to change of ownership or leasing arrangement subsequent to September 1, 1984.

   - Case-Mix Index - A relative measure of resource utilization at a hospital.

   - Cost - Total SC Medicaid allowable costs of inpatient services, unless otherwise specified.

   - CRNA - Certified Registered Nurse Anesthetist.

   - Diagnosis Related Groups (DRGs) - A patient classification that reflects clinically cohesive groupings of patients who consume similar amounts of hospital resources.

   - Direct Medical Education Cost - Those direct costs associated with an approved intern and resident or nursing school teaching program as defined in the Medicare Provider Reimbursement Manual, publication HIM-15.

17. Inpatient - A patient who has been admitted to a medical facility on the recommendation of a physician or a dentist and who is receiving room, board and professional services in the facility. A patient who is admitted to an acute care facility and expires while in the facility shall be considered an inpatient admission regardless of whether the stay was overnight.

18. Inpatient Services - Those items and services ordinarily furnished by a hospital for the care and treatment of patients. These items and services are provided under the direction of a licensed practitioner in accordance with hospital by-laws. Such inpatient services must be medically justified documented by the physician's records and must comply with the requirements of the state's designated Peer Review Organization (PRO). Emergency room services are included in the inpatient rate only when a patient is admitted from the emergency room.

19. Intensive Technical Services - Those services rendered to patients having extreme medical conditions requiring total dependence on a life support system.

20. Long-Term Care Psychiatric Hospital - An institution licensed as a hospital by the applicable South Carolina licensing authority, certified for participation in Medicare XVIII program, primarily engaged in providing psychiatric services for the diagnosis and treatment of mentally ill persons with a Medicaid inpatient acute average length of stay greater than twenty-five (25) days.

21. Low Income Utilization Rate - The sum of fractions a and b.

    a. Numerator:

       Total Medicaid inpatient and outpatient charges, including charges for Medicaid managed care, dual (Medicare/Medicaid) eligible, and Medicaid with commercial insurance patients, plus cash subsidies for patient services received directly from state and local governments.

       Denominator:

       Total inpatient and outpatient charges (including cash subsidies) for patient services.

    b. Numerator:

       Total hospital charges for inpatient hospital services attributable to charity care less cash subsidies from "a" above.

       Denominator:

       Total inpatient charges for patient services.

       Cash subsidies are defined as monetary contributions or donations received by a hospital. These contributions must originate from state and local governments. All contributions received will be considered as cash subsidies. If the funds are not designated for a specific type of service (i.e. inpatient services), they shall be prorated based on each type of service revenue to the hospital's total revenue (i.e. total inpatient revenues divided by total patient revenues).

Charity care is defined as care provided to individuals who have no source of payment, third party or personal resources. Total charges attributable to charity care shall not include contractual allowances and discounts or charges where any payment has been received for services rendered. An individual application, client specific, must be taken and a decision rendered in each applicant's case.

22. Medicaid Day Utilization Percentage - A facility's percent of hospital Medicaid eligible inpatient acute days, including Medicaid managed care days, dual eligible (Medicare/Medicaid) days, and Medicaid with commercial insurance days plus administrative days divided by total hospital inpatient acute days plus administrative days. The source of patient day information will be the filed CMS-2552 worksheet S-3, DHHS's MARS report, DHHS's administrative days report and requested supplemental worksheets.

23. Medically Necessary Services - Services which are necessary for the diagnosis, or treatment of disease, illness, or injury, and which meet accepted standards of medical practice. A medically necessary service must:

    a. Be appropriate to the illness or injury for which it is performed as to type and intensity of the service and setting of treatment;

    b. Provide essential and appropriate information when used for diagnostic purposes; and

    c. Provide additional essential and appropriate information when a diagnostic procedure is used with other such procedures.

24. Outliers - There are two kinds of outliers: day outliers and cost outliers. A day outlier occurs when the patient's length of stay exceeds a specified amount. A cost outlier occurs when a patient's charges exceed a specified amount. In both cases, the hospital will receive reimbursement for the outlier in addition to the base DRG payment. Outliers only apply to claims paid per discharge.

25. Outpatient - A patient who is receiving services at a hospital which does not admit him/her and which is not providing him/her with room and board services.

26. Outpatient Services - Those diagnostic, therapeutic, rehabilitative, or palliative items or services furnished by or under the direction of a physician or dentist to an outpatient by an institution licensed and certified as a hospital. This service will include both scheduled services and the provision of service on an emergency basis in an area meeting licensing and certification criteria.

27. Principal Diagnosis - The diagnosis established after medical evaluation to be chiefly responsible for causing the patient's admission to the hospital.

2. The remaining DRGs shall be reimbursed under the per discharge payment method using the following case volume/variance rules.

   - If the DRG had 30 or more cases

   - If the DRG has between 22 and 29 cases and a coefficient of variance (mean charge for the DRG divided by the standard deviation for the DRG) of less than 2.00.

B. Allowable Inpatient Costs

For acute care, freestanding short term psychiatric, and long term acute care hospital inpatient rates effective on and after October 1, 2009, allowable inpatient cost information of covered services from each acute care hospital's FY 2006 cost report will serve as the basis for computation of the hospital specific cost per discharge and the statewide average cost per day. All contracting SC acute care hospitals as well as out of state contracting border hospitals with SC Medicaid inpatient claim utilization of at least 200 claims were used in this analysis. The source document for Medicaid allowable inpatient costs will be the CMS-2552, which is the Medicare/Medicaid cost report. Allowable Medicaid inpatient costs will be determined in accordance with the Provider Reimbursement Manual Publication 15. However, no adjustment will be made to carve out the private room differential costs. Medicare's recent policy change relating to the inclusion of Medicaid labor and delivery patient days in the Medicare Disproportionate Share calculation effective for cost reporting periods beginning on and after October 1, 2009 will have no impact on the calculation of allowable Medicaid inpatient hospital costs beginning on and after October 1, 2009. Hospitals will continue to determine patient days for maternity patients in accordance with the provisions of the Provider Reimbursement Manual HIM-15, section 2205.2. Inpatient 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 2006 SCDHHS MARS paid claims summary data report for each acute care hospital identified above will also be used during the analysis.

1. As filed total facility costs are identified from each facility's FY 2006 Worksheet B Part I (BI) CMS-2552 cost report. Total inpatient facility costs would include operating, capital, direct medical education, and indirect medical education costs. Swing bed and Administrative Day payments are deducted from the adult and pediatric cost center on the CMS-2552 as well as CRNA costs identified under BI, column 20. Observation cost is reclassified.

2. As filed total facility costs will be allocated to Medicaid inpatient hospital cost using the following methods.

   a. 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 (as reported on Worksheet DII or D-4 for Medicaid inpatient ancillary charges) to yield total SC Medicaid inpatient ancillary costs.

   b. SC Medicaid routine service costs will be computed by dividing each routine cost center by total patient days of the applicable routine cost center and then multiplying by the applicable SC Medicaid covered patient days. Total SC Medicaid routine costs will represent the accumulation of the SC Medicaid cost determined from each applicable routine cost center.

expenditures component of the Consumer Price Index and represents the current unadjusted twelve months experience ending June 30, 2007. For the per discharge rate setting, different inflation factors were determined based upon the hospital's fiscal year end(e.g. FYE 9/30/06 trend rate = .1248736, FYE 6/30/06 trend rate = .1359612, etc.). For the statewide per diem rate setting, only one inflation factor was determined and used for rate setting purposes. The trend factor used was .1248736. For per discharge and statewide per diem rates effective October 1, 2009, no additional trend was applied, as trend was incorporated into the calibration factor.

2. Free-Standing Long-Term Psychiatric Hospitals

For the freestanding long-term psychiatric hospital rates, the annual trend rates used to trend the FY 1990 SC Medicaid inpatient cost to the current rate period are as follows:

Period	TEFRA Non-PPS Rate of Increase
10/1/89 - 9/30/90	5.2%
10/1/90 - 9/30/91	4.4%
10/1/91 - 9/30/92	4.7%
10/1/92 - 9/30/93	4.7%
10/1/93 - 9/30/94	4.9%

Because these rates of increase are based on the Federal fiscal year, they will be adjusted to coincide with the State fiscal year.

The following calculations are performed to adjust FY 1990 costs to the reimbursement period.

a. To compensate for varying fiscal year ends, each facility's 1990 fiscal year cost will be adjusted to reflect dollars as of a single point in time (12/31/90). For example, a facility with a 6/30 fiscal year end will have an additional inflation factor applied to its costs. This inflation factor will be calculated by dividing the number of days between 6/30 and 12/31 (184) by 365. The resulting percent will be multiplied by the applicable TEFRA Non-PPS factor. This factor will be calculated by adding 1.00 to the sum of the values derived from multiplying 5.2% times 9/12 (9 months of FY 1990) and multiplying 4.4% times 3/12 (3 months of FY 1991).

b. A factor will be calculated to inflate costs from July 1, 1990 (midpoint of December 31, 1990 fiscal year) to January 1, 1994 (midpoint of June 30, 1994 fiscal year). Adding 1.00 to a through e below and then multiplying these numbers together calculate this factor.

   i. 3/12 x .052
      (three months of the FY 1990 rate of increase)

   ii. 12/12 x .044
      (twelve months of the FY 1991 rate of increase)

1. Hospital Specific Per Discharge Rates

The following methodology is employed in the computation of the hospital specific per discharge rates effective October 1, 2008:

a. SC Medicaid allowable inpatient costs as described in Section IV for each acute care hospital are broken down into the following cost components:

   i. base inpatient costs (total-DME-IME-capital)
   ii. direct medical education costs (including capital)
   iii. indirect medical education costs
   iv. capital costs (less DME capital)

b. Each cost component identified in 1 a. above is divided by the number of inpatient claims incurred by the hospital during its FY 2006 cost reporting period to arrive at a cost per claim for each cost component. Inpatient claims data is derived from the SCDHHS MARS paid claims summary report.

c. Each cost component identified in 1 b. above (except for capital and DME capital) is trended by the inflation factor described under Section IV C 1. The four trended cost components are then summed to determine the total allowable SC Medicaid inpatient costs on a per claim basis that will be used for per discharge rate setting for each acute care hospital.

d. The total allowable SC Medicaid trended inpatient costs on a per claim basis as identified in 1 c above for each acute care hospital is reduced by the outlier set aside amount of 4.07%, and case mix adjusted to establish an ``adjusted per discharge rate'' for each acute care hospital.

e. The "adjusted per discharge rate" identified in 1.d. above is multiplied by a calibration factor to determine each acute care hospital's "actual per discharge rate" effective October 1, 2009. The purpose of the inpatient base rate calibration process is to normalize each hospital's per discharge base rate for differences between its mix of cases and the statewide Medicaid mix of cases. Some of the more relevant differences include:

   1) The starting individual base rate for each hospital is calculated based upon its individual cost to charge ratio times the facility's allowed charge per case. Because portions of the reimbursement methodology are based upon the statewide cost to charge ratio, to the extent that a facility varies (either positively or negatively) from the statewide cost to charge ratio, the financial impact of the starting base rate will be influenced.

2) To the extent that a facility varies from other statewide measures used in the methodology (i.e. DRG relative weights, average length of stay, mix of inlier and outlier cases, reimbursement methodology, etc), the financial impact of the overall system to the facility will be influenced.

Effective October 1, 2009, to calibrate the starting reimbursement rates for the differences noted above, a two-step model is employed. In the first iteration of the model, the starting rates are simulated using the statewide measures, case rates, per diem rates, and reimbursement rules. Once that step is completed, the resulting model payments are compared to an estimated cost target developed by the Medicaid Agency for each eligible hospital that represents 100% of allowable Medicaid inpatient hospital costs effective October 1, 2009. The amount of difference (either positive or negative) is compared to the payments made for all discharges. From this relationship, a factor is developed that is used to adjust the hospital's base rate (per diem cases are described under section 2.g.) to move the facility closer to the target reimbursement. For example, if a hospital is $1,000,000 short of the targeted reimbursement amount and that facility had $10,000,000 in payments, a factor of 1.10 would be applied to its base rate. Conversely, if that same hospital had model payments of $1,000,000 in excess of its target, an adjustment of .90 would be applied to the facility's base rate.

f. In order to allocate the ``actual per discharge rate'' of each hospital into the four cost components (i.e. base, DME, IME, and capital), each trended cost component identified in 1 c above is divided by the sum of the four trended cost components to determine each component's percentage of the total trended Medicaid inpatient costs on a per claim basis. This percentage is then applied against the ``actual per discharge rate'' determined in 1 e above to determine each component's portion of the ``actual per discharge rate''.

g. A statewide per discharge rate will be established for teaching hospitals with an intern/resident program, teaching hospitals without an intern/resident program, and non-teaching hospitals. Hospitals that will receive the appropriate statewide per discharge rate will include long term acute care hospitals, freestanding short term psych hospitals, out of state contracting acute care hospitals with SC Medicaid inpatient claims utilization of less than 200 claims, new acute care hospitals that come on line after 2006, and contracting acute care hospitals with high cost/low SC Medicaid inpatient claim utilization. The October 1, 2009 statewide per discharge rate will be held to the October 1, 2008 payment rate.

h. The rate determined above is multiplied by the relative weight for that DRG to calculate the reimbursement for a per case DRG claim. Outlier amounts will be added if applicable.

1. Statewide Per Diem Rates

Data from claims incurred during the period October 1, 2005 through September 30, 2006 were used to calculate the per diem rates. The following steps are involved in the computation of the statewide per diem rates effective October 1, 2008:

a. Calculate the total charges associated with each per diem DRG.

b. Calculate the total days of hospitalization for each per diem DRG.

c. Divide the total charges for each per diem DRG by the total number of days of hospitalization for each per diem DRG. The average charge per day is multiplied by the statewide cost-to-charge ratio of .368735 to calculate the average cost per day for each per diem DRG. The statewide cost-to-charge ratio is determined using the HFY 2006 hospital cost reports.

d. Once the charge has been converted to a statewide cost, multiply the cost by the appropriate trend factor as referred to in Section IV C 1 of the plan. For DRGs with no activity, per diem rates were set at the statewide average.

e. In order to allocate each of the statewide per diem DRG rates into the four cost components (i.e. base, DME, IME, and capital), each trended cost component identified in Section V A I c of the plan is divided by the sum of the four trended cost components to determine each component's percentage of the total trended Medicaid inpatient costs in the aggregate. This aggregate percentage per cost component is then applied against each statewide per diem DRG rate to determine each component's portion. The aggregate percentage per cost component used for the October 1, 2008 statewide per diem rates are as follows:(1) Base = 81.01%; (2) DME = 4.34%; (3) IME = 7.30%; (4) Capital = 7.35%. Once the analysis was completed, separate statewide per diem rates were established for teaching hospitals with an intern/resident program, teaching hospitals without an intern/resident program, and non-teaching hospitals.

f. All acute care hospitals, long term acute care hospitals, and freestanding short term psychiatric hospitals will be reimbursed the applicable set of statewide per diem rates. The October 1, 2009 statewide per diem rates will be held to the October 1, 2008 statewide per diem payment rates.

g. Effective 1, 2009, in order to convert the statewide inpatient per diem rate payments into hospital specific payments, a hospital specific inpatient per diem multiplier will be developed for each hospital. The inpatient per diem multiplier will convert the calculated statewide per diem claims payment to a hospital specific payment that will be limited to no more than 100% of projected inpatient costs effective October 1, 2009. Hospitals that receive a hospital specific inpatient per diem multiplier will be those eligible to receive retrospective cost

by multiplying the applicable DRG relative weight by the hospital discharge rate and dividing by twice the average length of stay for the DRG. However, when a patient is admitted and discharged, and subsequently readmitted on the same day, the hospital will be paid only one per discharge or per diem payment as appropriate.

F. Payment for Swing Bed Days

Acute care facilities will be reimbursed for qualifying skilled and intermediate care Medicaid patients in accordance with the daily rate schedule shown below.

October 1, 2003 - September 30, 2004	116.13
October 1, 2004 - September 30, 2005	121.92
October 1, 2005 - September 30, 2006	129.16
October 1, 2006 - September 30, 2007	136.24
October 1, 2007 - September 30, 2008	141.52
October 1, 2008 - September 30, 2009	146.98
October 1, 2009 -	153.57

This rate calculation is described in the Nursing Home State Plan Attachment 4.19-D.

G. Payment for Administrative Days

Acute care facilities will be reimbursed for Medicaid eligible skilled or intermediate patients who no longer require acute care and are waiting for nursing home placement. Administrative days must follow an acute inpatient hospital stay and will be covered in any hospital as long as a nursing home bed is not available. Reimbursement for administrative days is described below.

1. Each administrative day will be paid in accordance with the rate schedule shown below. This daily rate will be considered payment in full. There will be no cost settlement. This rate is a combination of the swing bed rate, as defined above, plus the trended Alternative Reimbursement Method (ARM) rate for pharmaceutical services.

October 1, 2003 - September 30, 2004	123.57 (ARM 7.44)
October 1, 2004 - September 30, 2005	129.75 (ARM 7.83)
October 1, 2005 - September 30, 2006	136.99 (ARM 7.83)
October 1, 2006 - September 30, 2007	144.07 (ARM 7.83)
October 1, 2007 - September 30, 2008	149.71 (ARM 8.19)
October 1, 2008 - September 30, 2009	155.56 (ARM 8.58)
October 1, 2009 -	162.55 (ARM 8.98)

2. Patients who require more intensive technical services (i.e. patients who have extreme medical conditions which require total dependence on a life support system) will be reimbursed using rates from the following schedule.

October 1, 2003 - September 30, 2004	188.00
October 1, 2004 - September 30, 2005	197.00
October 1, 2005 - September 30, 2006	206.00
October 1, 2006 - September 30, 2007	215.00
October 1, 2007 - November 30, 2008	225.00
December 1, 2008 -	364.00

This rate calculation is described in the Nursing Home State Plan Attachment 4.19-D.

VII. Disproportionate Share

A. Payments

Disproportionate share hospital (DSH) payments shall be made in accordance with the requirements of Section 1923 of the Social Security Act. DSH payments will be paid to those facilities meeting the requirements specified in Section II 12. For clarification purposes, the South Carolina Medicaid State Plan rate year for DSH payment purposes is October 1 through September 30. For FFY 2010, qualification data will be based upon each hospital's fiscal year 2008 cost reporting period.

1. Effective October 1, 2009, the hospital specific DSH limit will be set as follows:

a. The hospital specific DSH limit for all SC general acute care hospitals that contract with the SC Medicaid Program will be equal to one hundred percent (100%) of the unreimbursed hospital cost for SC uninsured patients and SC Medicaid managed care patients (including PACE Program participants). The hospital specific DSH limit for all general acute care border hospitals (in North Carolina and Georgia) and SC non-general acute care hospitals contracting with the SC Medicaid Program will be equal to sixty percent (60%) of the unreimbursed hospital cost for SC uninsured patients and SC Medicaid managed care patients (including PACE Program participants). The stand alone SCHIP Program named ``Healthy Connections Kids'' is operated as a managed care program but its costs are not eligible for participation in the SC Medicaid DSH Program.

Except for the SC Department of Mental Health (SCDMH) hospitals, for FFY 2010, each hospital's hospital specific DSH limit will be calculated as follows:

i) The unreimbursed cost of providing inpatient and outpatient hospital services to the uninsured will be determined by taking each hospital's fiscal year 2008 cost reporting period charges and multiplying them by the hospital's FY 2008 Medicaid inpatient and outpatient cost to charge ratios to determine the base year cost for the uninsured. Next, the unreimbursed cost of providing inpatient and outpatient hospital services to the Medicaid managed care enrollees will be determined by taking each hospital's July 1, 2008 through June 30, 2009 charges and multiplying them by the hospital's FY 2008 Medicaid inpatient and outpatient cost to charge ratios to determine the base year cost for the Medicaid managed care enrollees. Because hospital fiscal year 2008 data will be used to determine the cost of

providing inpatient and outpatient hospital services to the uninsured, the cost will be trended from each hospitals fiscal year end to June 30, 2009, using the applicable CMS Market Basket Indices described in (A)(2) of this section. The cost of providing inpatient and outpatient hospital services to Medicaid managed care enrollees will receive no additional trend since the cost will be determined using charge and payment data which covers the period July 1, 2008 through June 30, 2009. The cost of the uninsured and Medicaid managed care for each hospital as determined above will be summed and reduced by payments received from or for SC uninsured patients and SC Medicaid managed care patients to determine the total unreimbursed cost for each DSH hospital. No adjustment will be made for SC's implementation of its stand alone SCHIP program.

ii) For FFY 2010, each SCDMH hospital's specific DSH limit will be calculated using FYE June 30, 2008 cost report data for its SC uninsured. Each hospital's total allowable cost will be inflated from its base year end to June 30, 2009 using the CMS Market Basket Indices described in (A)(2) of this section. The inflated cost will be divided by total FYE June 30, 2008 acute care hospital days to determine a cost per day amount. This cost per day amount will be multiplied by the FYE June 30, 2008 acute care hospital days associated with SC uninsured to determine the total amount of uninsured cost eligible under the hospital specific DSH limit. The inflated cost of each hospital determined above will be reduced by payments received from or for SC uninsured patients to determine the total unreimbursed uninsured cost for each DSH hospital. In the event that any of the SCDMH hospitals provided inpatient hospital services for SC Medicaid managed care patients during FYE June 30, 2009, the previous methodology outlined above will be used to determine the unreimbursed Medicaid managed care cost to be added to the unreimbursed uninsured cost previously described except that FYE June 30, 2009 data will be used in lieu of FYE June 30, 2008 data.

iii) For hospitals that, during the base year actually began operations after the close of the base calendar year (i.e. December 31) but before October 1, 2009, the hospital specific DSH limit will be determined using the facility's unreimbursed cost of providing inpatient and outpatient hospital services to the uninsured and Medicaid managed care enrollees incurred from its date of operation through the end of its fiscal year. This data will be annualized with appropriate trending (i.e. a deflation adjustment).

iv) In the event the sum of the hospital specific DSH limits exceeds the total Medicaid (federal and state) allotment amount, the hospital specific DSH amounts will be decreased proportionately to ensure the hospital specific DSH payments are within the allotment amount.

2. The following CMS Market Basket indices will be applied to the hospitals' base year cost.

CY 2008	3.3%
CY 2009	3.6%

3. In the event that the sum of the hospital specific DSH limits falls below the annual total Medicaid DSH allotment beginning on and after October 1, 2009, the Medicaid Agency will trend each hospitals' base year cost using the midpoint to midpoint inflation method using the applicable CMS Market Basket Indices. Costs will be inflated through the Medicaid State Plan rate year.

4. All disproportionate share payments will be made by adjustments during the applicable time period.

B. Additional Requirements

Effective October 1, 2005, all qualifying DSH hospitals must adhere to the following rules for participation in the South Carolina Medicaid DSH Program.

1. Each hospital will be responsible for understanding the SC Medicaid DSH Program in order to provide the proper requested information required for DSH qualification and payment.

2. Each hospital agrees to participate in DSH data reviews conducted by SCDHHS and/or CMS, as well as audits of the DSH program data performed by an independent auditor hired by SCDHHS.

1. Utilization Review 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 to 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 hybrid 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.

1. Acute Care Hospitals

a. All acute care hospitals contracting with the SC Medicaid program must submit the CMS-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). The CMS-2552 cost report submitted to SC Medicaid should be the same as the cost report submitted to Medicare except for SC specific reporting requirements. Only hospitals with low SC Medicaid inpatient utilization (less than 10 inpatient claims) will be exempt from this requirement.

b. Cost report data will be used for retrospective cost settlements, cost analysis and disproportionate share purposes. Cost report data will be also be used for future rate setting purposes.

c. 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.

2. Psychiatric Residential Treatment Facilities

All psychiatric residential treatment facilities will submit the CMS-2552 form as well as their financial statements. The CMS-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, the medical information contained on claims and information contained on supplemental