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

Centers for Medicaid, CHIP, and Survey & Certification

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

JUN 29 2011

RE: State Plan Amendment SC 10-013

Dear Mr. Keck:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 10-013. Effective October 1, 2010 this amendment proposes to revise the inpatient hospital payment methodology. Specifically, the following changes are being proposed: update the per discharge and per diem rates based on the most recent filed cost reports; implement a retrospective cost based reimbursement methodology for non-state owned government long-term care psychiatric hospitals; include certified public expenditure protocol; update the hospital specific disproportionate share hospital (DSH) limits; implement the final DSH rule published on December 19, 2008; update the CMS market basket index used to establish interim DSH limits and payments; establish separate DSH pools for Mental Health hospitals and all other hospitals; and provide for redistribution of any DSH funds recovered from hospitals based on final DSH audits .

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 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, 2010. 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.

Sincerely

//s//

Cindy Mann
Director, CMCS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

REVISED 6/8/11 TO REFLECT ADDITIONAL PAGES

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: SC 10-013

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, 2010

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 2011 ($7.2 Million)
b. FFY 2012 $8.9 Million

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A, pages 1 - 6, 11, 13, 15 - 19, 24 - 28b, 30 and 32 through 39

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-A, pages 1 - 6, 11, 13, 15 - 19, 24 - 28b, 30 and 32 through 33

10. SUBJECT OF AMENDMENT:
Effective October 1, 2010,annual updates to: (1) October 1, 2010 inpatient rates/multipliers; (2) FFY 2011 DSH Allotment; (3) Base Year Cost/Data Reports used for FY 2011 DSH; (4) update to cost components for each hospital's specific DSH limit; (5) creation of two DSH payment pools effective October 1, 2010; and (5) redistribution of October 1, 2010 DSH allotment based upon results of audits.

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:
[redacted]

13. TYPED NAME:
Emma Forkner

14. TITLE:
Director

15. DATE SUBMITTED:
December 30, 2010

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:

18. DATE APPROVED:
06-29-11

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
OCT - 1 2010

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME: William Lasowski

22. TITLE:
Deputy Director, CMCS

23. REMARKS:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF SOUTH CAROLINA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
INPATIENT HOSPITAL AND PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY CARE

I. General Provisions

A. Purpose

This plan establishes:

1. a retrospective reimbursement system for qualifying acute care hospitals as defined in the plan, non-state owned governmental long-term care psychiatric hospitals and Department of Mental Health long-term psychiatric hospitals
2. a prospective reimbursement system for all other acute and non-acute care hospitals providing inpatient hospital services and
3. a prospective payment reimbursement system for private psychiatric residential treatment services and a retrospective reimbursement system for state-owned governmental and non-state owned governmental psychiatric residential treatment services in accordance with the Code of Federal Regulations.

It describes principles to be followed by Title XIX inpatient hospital and psychiatric residential treatment providers and presents the necessary procedures for setting rates, making adjustments, calculating retrospective cost settlements for qualifying acute care hospitals, auditing cost reports and managing the hospital disproportionate share (DSH) program.

B. Objectives

Effective October 1, 1997, the Balanced Budget Act (BBA) of 1997 repeals the OBRA 1981 requirement. In its place, the BBA of 1997 provides for a public process for determination of hospital payment rates. This public process will take place for all changes in payment for inpatient hospital and psychiatric residential treatment facility services and disproportionate share.

Inpatient hospital reimbursement shall be made in accordance with the upper payment limit requirements of Section 447.272.

C. Overview of Reimbursement Principles

1. The South Carolina Medicaid Program will reimburse qualified providers for inpatient institutional services using one or more of the following methods.

a. Prospective payment rates will be reimbursed to contracting

out-of-state acute care hospitals with SC Medicaid fee for service inpatient claim utilization of less than 200 claims during its cost reporting period.

b. Reimbursement for out of state border general acute care hospitals with S.C. Medicaid fee for service inpatient claims utilization of at least 200 claims and all S.C. non-general acute care hospitals (i.e. long term acute care hospitals, free standing short-term psychiatric hospitals, and free standing long-term psychiatric hospitals) will be based on a prospective payment system that will be further limited to no more than one hundred percent of the hospital's allowable SC Medicaid inpatient cost.

c. Retrospective inpatient cost settlements will be determined for all contracting SC general acute care hospitals, all non-state owned governmental long-term care psychiatric hospitals, all contracting SC psychiatric hospitals owned by the SC Department of Mental Health, and qualifying hospitals that employ a burn intensive care unit.

2. Medicaid reimbursement to a hospital shall be payment in full. Hospitals may not separately bill the patient or the Medicaid program for medical services rendered during an inpatient stay, except as provided in Section III of this plan and/or coinsurance. Hospitals may submit a claim for payment only upon final discharge of the patient, with the exception of long-term care psychiatric hospital claims and psychiatric residential treatment facility claims.

3. Payment for all hospitals (except freestanding long-term care psychiatric hospitals) will be made based on a hybrid payment system which compensates hospitals either an amount per discharge (per case) for a diagnosis related group or a per diem rate.

4. For discharges paid by the per case method under the hybrid payment system, South Carolina specific relative weights and rates will be utilized. Effective October 1, 2007, the Medicare DRG classification system that will be used will be DRG grouper version 24. The relative weights will be established based on a comparison of charges for each DRG category to charges for all categories. South Carolina's historical Medicaid claims database incurred from July 1, 2005 through June 30, 2006 will be used to establish the DRG relative weights.

5. For discharges paid by the per diem method, statewide per diem rates are established for the following categories of hospitals: teaching hospitals with an intern/resident program, teaching hospitals without an intern/resident program, and non-teaching hospitals. Effective October 1, 2008, facilities will receive the appropriate per diem rate times the number of days of stay, (subject to the limits defined in this plan) multiplied by the hospital specific inpatient per diem multiplier.

6. An outlier set-aside adjustment (to cover outlier payments described in 9 and 10 of this section) will be made to the per discharge rates.

7. Payment for services provided in freestanding long-term care psychiatric facilities shall be based on the statewide average per diem for psychiatric long-term care. The base per diem rate will be the statewide total costs of these psychiatric services divided by total psychiatric days.

8. The payments determined under both payment methods, the hybrid payment system for general acute care hospitals, including acute psychiatric and rehabilitation units, and short term care psychiatric hospitals and the per diem method for psychiatric long-term care facilities, will be adjusted to recognize facility specific costs associated with direct and indirect medical education, capital and ancillary services as appropriate. In addition to the claims payment, hospitals may receive other payments as outlined in this Attachment. Some examples are as follows: Section VI J describes hospital cost settlements and Section VII describes Disproportionate Share Hospital payments.

   Effective October 1, 1999, South Carolina Department of Mental Health hospitals will be reimbursed 100% of their allowable Medicaid inpatient cost through a retrospective cost settlement process. For clarification purposes, settlements will be determined on a per patient day basis. Effective October 1, 2010, non-state owned governmental long-term care psychiatric hospitals will be reimbursed 100% of their allowable Medicaid inpatient cost through a retrospective cost settlement process.

9. Special payment provisions, as provided in Section VI A of this plan, will be available under the hybrid payment system for discharges paid by DRG which are atypical in terms of patient length of stay or costs of services provided during the stay. These cases will be referred to as outliers. Special payment policies, as specified in Section VI C and D of this plan, will also be made for cases involving a transfer of a patient from one hospital to another, or a readmission of a patient following an earlier discharge. These provisions are not applicable to long-term psychiatric and RTF claims.

10. Reduced payment, as specified in Section VI B of this plan, will be made for cases paid on a per diem basis having stays exceeding two hundred percent of the statewide geometric average length of stay.

11. A rate reconsideration process will be available to hospitals that have higher costs as a result of conditions described in IX A of this plan.

12. Disproportionate share payments will be paid to qualifying hospitals in accordance with the requirements specified in Section VII of this plan.

13. Payment for services provided in psychiatric residential treatment facilities shall be an all-inclusive per diem rate. Section II paragraph 30 of this plan defines the costs covered by the all-inclusive rate. Each facility's per diem rate will be calculated using base year data trended forward. Section V B describes the rate calculation.

14. Effective for admissions on or after January 1, 2004 a standard co-payment amount of $25 per admission will be charged when a co-payment is applicable.

15. Effective for services provided on or after July 1, 2004, qualifying hospitals with burn intensive care units will receive annual retrospective cost settlements for the total cost of 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, 2010, 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.

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

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

8. CRNA - Certified Registered Nurse Anesthetist.

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

10. 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.

11. Discharge - The release of a patient from an acute care facility. The following patient situations are considered discharges under these rules.

    a. The patient is formally released from the hospital.

    b. The patient is transferred to a long-term care level or facility.

    c. The patient dies while hospitalized.

    d. The patient leaves against medical advice.

    e. In the case of a delivery, release of the mother and her baby will be considered two discharges for payment purposes. In case of multiple births, each baby will be considered a separate discharge.

    f. A transfer from one hospital to another will be considered a discharge for billing purposes but will not be reimbursed as a full discharge except as specified in Section VI. Cases involving discharges from one unit and admission to another unit within the same or a different general acute care hospital shall be recognized as two separate discharges for reimbursement purposes. The DRG assignment for each case will be assigned based on services provided at the point of discharge.

12. Disproportionate Share Hospitals - South Carolina and border state's (Georgia and North Carolina) contracting acute care inpatient hospitals whose participation in the SC Medicaid Program and services to low income clients is disproportionate to the level of service rendered in other participating hospitals shall be considered disproportionate share.

    Effective October 1, 2008, hospitals must satisfy one of the following criteria in order to qualify for the SC Medicaid DSH Program:

    1. Be a licensed SC general acute care hospital that contracts with the SC Medicaid Program or;

    2. Be a SC psychiatric hospital that is owned by the SC Department of Mental Health that contracts with the SC Medicaid Program or;

    3. Be a general acute care border hospital (in North Carolina or Georgia) with SC Medicaid fee for service inpatient claims utilization of at least 200 inpatient claims per year in the base year or any SC non-general acute care hospital that contracts with the SC Medicaid Program whose base year's Medicaid inpatient utilization rate is at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the State or whose base year's low-income utilization rate exceeds 25%.

    In addition to the above criteria, hospitals must satisfy the next two criteria in order to qualify for the SC Medicaid DSH Program:

    a. Hospitals must have a Medicaid day utilization percentage of at least one percent.

b. Hospitals must have at least two (2) obstetricians with staff privileges who have agreed to provide obstetrical services to Medicaid patients on a non-emergency basis. In the case of a hospital located in a rural area (as defined for purposes of section 1886 of the Social Security Act), the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures. This rule does not apply to a hospital that did not offer non-emergency obstetric services to the general population as of December 22, 1987.

Information pertaining to the base year(s) will be collected during the second and third quarter of the calendar year and will be used to determine which hospitals qualify for disproportionate share. Financial and statistical information used to determine disproportionate share qualification and payment will be submitted and/or verified on Medicaid supplemental worksheets. The supplemental worksheets must be completed correctly. Data will be verified by the DHHS using appropriate sources, including, but not limited to, the CMS 2552 and the DHHS inpatient MARS report and administrative days report. Disproportionate share eligibility does not qualify for the rate reconsideration process.

The disproportionate share payment methodology is set forth is Section VII A.

13. General Acute Care Hospital - An institution licensed as a hospital by the applicable South Carolina licensing authority and certified for participation in the Medicare (Title XVIII) program.

14. Geometric Mean - The measure of central tendency of a set of n values computed by extracting the nth root of the product of the values.

Example: The geometric mean of 2, 4 and 1 is $\sqrt[3]{2x4x1} = 2$

15. Indirect Medical Education Cost - Those indirect costs resulting from the additional tests and procedures performed on patients because the hospital is a teaching institution. Such costs are determined using the number of interns and residents per operating bed in a Federally derived indirect medical education equation.

16. Indirect Medical Education Percentage - The Medicare indirect medical education formula (adjusted to include psychiatric and rehab subprovider beds) is used to calculate indirect medical education cost. The formula used is as follows:

$C \times [(1 + (\text{interns and residents})/\text{beds})^{.405)} - 1]$

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. For clarification purposes one hundred percent of the South Carolina general acute care hospital provider tax will be considered an allowable Medicaid cost. 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, 2010, 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)

E. Medicaid Case-Mix Index

A case-mix index, which is a relative measure of a hospital's resource use, will be used to adjust the per discharge cost amounts to the statewide average case-mix. For each hospital the per discharge case-mix index will be computed by multiplying the number of incurred SC Medicaid inpatient claims during its FYE 2006 cost reporting period in each per case DRG by the DRG relative weight, summing these amounts and dividing by the sum of the total per case discharges. DRG grouper version 24 and the October 1, 2007 relative weights were used in the calculation of the case mix index for each hospital.

F. Outlier Set-Aside Factor

Cases were statistically tested to determine the amount of expense that would be set aside to be distributed as outlier payments. Cases in which the charge exceeded the arithmetic charge per case plus two times the standard deviation were flagged as an outlier for set aside purposes. The amount of charges that exceed the trim point was also calculated. This sum was divided by the total charges in the pricing dataset to determine the adjustment factor that would be used to reduce the individual hospital base rates for re-distribution as outlier payments. Only claims for cases to be paid by the per discharge method will be included in this analysis. The outlier set-aside factor for the hybrid payment system effective on and after October 1, 2008 will be 4.07%. The DHHS may adjust future set-asides to reflect more current information.

G. Psychiatric Residential Treatment Facility Costs

Psychiatric residential treatment facility per diem reimbursement rates, effective for dates of service beginning on or after 09/01/99, shall be calculated using each facility's desk-reviewed cost report data reflecting allowable costs in accordance with CMS Publication 15-1 and the all-inclusive rate definition. Cost will come from each facility's 1997 CMS-2552(Medicare/Medicaid Cost Report), with exception when applicable (e.g. professional service costs and subsequent period costs). If applicable, add-ons will be calculated and applied to the RTF rate for services required by the RTF program subsequent to the 1997 cost reporting period. These add-ons will be calculated using future cost report and/or budgeted cost and statistical data.

V. Reimbursement Rates

A. Inpatient Hospital

The computation of the hybrid payment system rates will require three distinct methods - one for computation of the hospital specific per discharge rates, a second for computation of the statewide per diem rates, and a third for computation of the statewide per diem rate for freestanding long-term care psychiatric facilities.

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, 2010. 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, 2010, 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, 2010. 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 fee for service 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, 2010 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.

2. 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, 2010 statewide per diem rates will be held to the October 1, 2008 statewide per diem payment rates.

g. Effective 1, 2010, 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, 2010. Hospitals that receive a hospital specific inpatient per diem multiplier will

be those eligible to receive retrospective cost settlements and those contracting out of state border hospitals that have SC Medicaid fee for service claims utilization of at least 200 claims. All other contracting hospitals will receive an inpatient per diem multiplier of 1.00. The inpatient multiplier will be applied after the inpatient per diem payment has been calculated prior to any reduction for third party liability or coinsurance. The hospital specific per diem multiplier and the hospital specific per discharge rate calibration factor are one in the same and the methodology employed by the Medicaid Agency to calculate these factors can be found under section V A 1 e.

Calibration of per diem rates is achieved using a similar methodology. Using the results of simulation model, the same calibration factor developed for case rates is applied to the applicable per diem rates for each DRG paid under that methodology. For example, if the per diem rate for a given DRG is $500.00 prior to TPL and a calibration adjustment of 1.10 was developed in the simulation iteration, a per diem payment of $550.00 prior to TPL would be allowed. Similarly, a calibration factor of .90 would result in a per diem payment of $450.00 prior to TPL.

3. Per Diem Prospective Payment Rate - Long-Term Psychiatric Facilities

Only freestanding long-term care psychiatric facilities are included in this computation.

a. Adjusted Medicaid inpatient room and board costs are summed across all participating freestanding long-term care psychiatric facilities. The number of days of care is summed across these facilities and the result is divided into the total adjusted costs to yield the statewide average per diem.

b. Hospital specific factors are added to the base rate, as was the case in Section V A. Medicaid days for freestanding long-term care psychiatric facilities are substituted in each computation for discharges. For freestanding long-term care psychiatric facilities providing ancillary services, an ancillary add-on is added to the base rate. The ancillary add-on is calculated in the same manner as the capital, DME and IME add-ons.

c. To determine the amount of reimbursement for a particular claim, the number of certified days of stay is multiplied by the per diem rate for long-term care psychiatric services. No outlier payments will be made for reimbursement to long-term care psychiatric facilities.

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 - September 30, 2010	153.57
October 1, 2010	154.67

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 - September 30, 2010	162.55 (ARM 8.98)
October 1, 2010	163.83 (ARM 9.16)

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.

This per diem rate will represent payment in full and will not be cost settled.

H. Payment for One-Day Stay

Reimbursement for one-day stays that group to per discharge DRGs (except deaths, false labor, normal deliveries (DRG 373) and normal newborns (DRG 391)) will be reimbursed a DRG per diem. A DRG per diem is equal to reimbursement for applicable DRG divided by the average length of stay for that DRG.

I. New Facilities/New Medicaid Providers

Payment rates for facilities that were not in operation or not contracting with the SC Medicaid Program during the base year will be determined as follows:

a. For hospitals under the hybrid payment system, the per discharge payment rate will be set at the applicable statewide average per discharge rate (i.e. teaching with intern/resident program. teaching without intern/resident program, and non-teaching). New facilities will receive the applicable statewide per diem rates as described in Section V A 2.

b. For freestanding long-term care psychiatric facilities, payment will be at the statewide average per diem for long term care psychiatric facilities plus projected capital and medical education costs as applicable.

c. For Residential Treatment Facilities, payments will be based on a statewide average of all the RTF rates.

J. Retrospective Hospital Cost Settlements

Effective for services provided on or after October 1, 2007, the following types of hospitals will receive retrospective Medicaid inpatient cost settlements. In calculating these settlements, allowable cost and payments will be calculated in accordance with the methodology described in Section VIII.

- All SC general acute care hospitals contracting with the SC Medicaid Program that qualify for the SC Medicaid DSH Program will receive retrospective cost settlements that, when added to fee for service and non fee for service (i.e. adjustment) payments, will represent one hundred percent (100%) of each hospital's allowable SC Medicaid inpatient costs.

- All SC psychiatric hospitals owned by the SC Department of Mental Health contracting with the SC Medicaid Program that qualify for the SC Medicaid DSH Program will receive retrospective cost settlements that, when added to fee for service and non fee for service (i.e. adjustment) payments, will represent one hundred percent (100%) of each hospital's allowable SC Medicaid inpatient costs.

- All qualifying hospitals that employ a burn intensive care unit that contract with the SC Medicaid Program will receive retrospective cost settlements that, when added to fee for service and non fee for service (i.e. adjustment) payments, will

represent one hundred percent (100%) of each hospital's allowable SC Medicaid inpatient costs.

- Effective October 1, 2010, all non-state owned governmental long-term care psychiatric hospitals will receive retrospective cost settlements that, when added to fee for service and non fee for service (i.e. adjustment) payments, will represent one hundred percent (100%) of each hospital's allowable SC Medicaid inpatient costs.

Effective October 1, 2010, contracting out of state border hospitals with SC Medicaid fee for service inpatient claims utilization of at least 200 claims, contracting SC long term acute care hospitals, and contracting SC short term and long term freestanding psychiatric hospitals (excluding SCDMH psychiatric hospitals and non-state owned governmental long-term care psychiatric hospitals) will not qualify for retrospective cost settlements. However, an annual analysis will be performed each cost reporting year to ensure that Medicaid reimbursement under the hybrid payment system does not exceed allowable Medicaid inpatient costs.

K. Graduate Medical Education Payments for Medicaid MCO Members

For clarification purposes, the SCDHHS will pay teaching hospitals for SC Medicaid graduate medical education (GME) cost associated with SC Medicaid MCO members. The managed care GME payment will be calculated the same as the medical education payment calculated by the fee-for-service program. It will be based on quarterly inpatient claim reports submitted by the MCO and the direct and/or indirect medical education add-on amounts that are paid to each hospital through the fee-for-service program. Payments will be made to the hospitals on a quarterly basis or less frequently depending on claims volume and the submission of the required data on the claim reports.

L. Co-Payment

Effective March 31, 2004, a standard co-payment amount of $25 per admission will be charged when a co-payment is applicable. The co-payment charged is in accordance with 42 CFR 447.53, 447.54(c) and 447.55. The inpatient cost settlement will include uncollected Medicaid co-payment amounts in accordance with 42 CFR 447.57.

M. Payment for Out of State Transplant Services

Payment for transplant services provided to South Carolina Medicaid recipients by out of state hospitals (i.e. other than the border hospitals of North Carolina and Georgia) will be based upon a negotiated price reached between the out of state provider and the Medicaid Agency. The negotiated price will include both the professional and the hospital component. Transplant services provided to Medicaid recipients in South Carolina DSH hospitals will be reimbursed in accordance with the payment methodology outlined in Attachment 4.19-A and 4.19-B (i.e. South Carolina general hospitals will be reimbursed allowable inpatient and outpatient costs in accordance with provisions of the plan while the physician professional services will be reimbursed via the physician fee schedule).

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 2011, qualification data will be based upon each hospital's fiscal year 2009 cost reporting period.

1. Effective October 1, 2010, the interim hospital specific DSH limit will be set as follows:

a. The interim 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, SC Medicaid managed care patients (including PACE Program participants), SC dual (Medicare/Medicaid) eligible patients, and SC Medicaid patients who have inpatient and outpatient hospital services reimbursed by a commercial carrier. 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, SC Medicaid managed care patients (including PACE Program participants), SC dual (Medicare/Medicaid) eligible patients, and SC Medicaid patients who have inpatient and outpatient hospital services reimbursed by a commercial carrier. The December 19, 2008 Final Rule (as well as instructions/guidance provided by Clifton Gunderson) relating to the audits of the Medicaid DSH plans will be the guiding document that hospitals must use in providing the DSH data. The stand alone SCHIP Program named "Healthy Connections Kids" is operated as a managed care program during FFY 2009 and thus its costs will not be included in the calculation of the interim hospital specific DSH limit effective October 1, 2010.

Except for the SC Department of Mental Health (SCDMH) hospitals, for FFY 2011, each hospital's interim hospital specific DSH limit will be calculated as follows:

i) The unreimbursed cost of providing inpatient and outpatient hospital services to the uninsured, dual eligibles, and Medicaid eligibles who have inpatient and outpatient hospital services reimbursed by a commercial carrier will be determined by taking each hospital's fiscal year 2009 cost reporting period charges for each group listed

above and multiplying that by the hospital's applicable FY 2009 inpatient and outpatient cost to charge ratios (i.e. Medicaid and Medicare) to determine the base year cost for this group. Next, the unreimbursed cost of providing inpatient and outpatient hospital services to the Medicaid managed care eligibles will be determined by taking each hospital's July 1, 2008 through June 30, 2009 charges and multiplying by the hospital's FY 2009 Medicaid inpatient and outpatient Medicaid cost to charge ratios to determine the base year cost for this group. In order to inflate each hospital's base year cost determined for each group identified above, each hospital's cost will be inflated from the base year to December 31, 2009 using the applicable CMS Market Basket Indice described in 2 of this section. The inflated cost of each hospital for each group determined above will be summed and reduced by payments received from or for SC uninsured patients, SC dual eligibles, SC Medicaid eligibles who have inpatient and outpatient hospital services reimbursed by a commercial carrier, and SC Medicaid managed care patients to determine the total unreimbursed cost for each DSH hospital.

ii) For FFY 2011, each SCDMH hospital's interim hospital specific DSH limit will be calculated using FYE June 30, 2009 cost report data for its SC uninsured, SC dual (Medicare/Medicaid) eligible, and SC Medicaid eligibles who have inpatient hospital services reimbursed by a commercial carrier. Each hospital's total allowable cost will be inflated from the base year to December 31, 2009 using the CMS Market Basket Indice described in (A)(2) of this section. The inflated cost will be divided by total FYE June 30, 2009 acute care hospital days to determine a cost per day amount. This cost per day amount will be multiplied by the FYE June 30, 2009 acute care hospital days associated with SC uninsured, SC dual eligible, and SC Medicaid eligibles who have inpatient hospital services reimbursed by a commercial carrier to determine the total amount of 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, SC dual eligibles, and SC Medicaid eligibles who have inpatient and outpatient hospital services reimbursed by a commercial carrier to determine the total unreimbursed cost of 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.

iii) For new S. C. general acute care hospitals which enter the SC Medicaid Program on or after October 1, 2010, their interim hospital specific DSH limits for the October 1, 2010 through September 30, 2011 Medicaid State Plan rate year (i.e. DSH payment period) will be based upon projected DSH

qualification, cost, charge and payment data that will be subsequently adjusted to reflect the audited DSH qualification, cost, charge and payment data resulting from the audit of the October 1, 2010 through September 30, 2011 Medicaid State Plan rate year.

iv) The SCDHHS will create two separate DSH pools for the calculation of the interim DSH payments effective October 1, 2010. The first DSH pool will represent the unreimbursed costs of the uninsured and Medicaid eligible recipients receiving inpatient psychiatric hospital services provided by South Carolina Department of Mental Health (SCDMH) hospitals. Under this pool, the SCDMH hospitals will receive (in the aggregate) up to one hundred percent of their specific DSH limit but not to exceed the aggregate FFY 2010 base DSH allotment payment amounts of all of the SCDMH hospitals. Next, the remaining DSH allotment amount beginning October 1, 2010 will be available to the remaining DSH qualifying hospitals. In the event that the sum of the hospital specific DSH limits of the remaining DSH qualifying hospitals exceeds the remaining DSH allotment amount beginning October 1, 2010, the hospital specific DSH limits will be decreased proportionately to ensure the hospital specific DSH limits are within the remaining October 1, 2010, DSH allotment amount.

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

CY 2009	3.6%

3. In the event that CMS is unable to provide the final FFY DSH allotments in a timely manner, the SCDHHS reserves the right to use the most recently published CMS Market Basket indices if there is room for additional DSH payments between the hospital specific DSH limit and the final FFY DSH allotment for the applicable FFY.

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

5. Effective October 1, 2010, all interim DSH payments will become final once the redistribution of any excess DSH payments have been made based upon the findings of the October 1, 2010 through September 30, 2011 DSH audit. See section IX(C)(1)(b)for additional information.

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.

2. an updated inpatient cost-to-charge ratio;

3. an analysis reflecting the financial impact of the reimbursement change effective on or after October 1, 2007.

The provider request will be reviewed by SCDHHS staff to determine if an interim settlement adjustment is justified based upon the best available information at the time.

D. For clarification purposes, all interim retrospective cost settlements will be subject to final audit. Any underpayment/(overpayment) identified as a result of the final audit will be paid or recouped accordingly.

IX. Changes to the Hybrid Payment System Rates

A. Rate Reconsideration

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

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

b. Changes in the case-mix since the base year. Such requests will be accompanied by documentation of the case-mix change using DRG case-mix and severity of illness measures. Use of the DRG case-mix index alone is not satisfactory for rate reconsideration under this part.

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 that clearly explains the circumstance, demonstration that the circumstance was extraordinary and unique to that facility, and the expenses associated with the circumstance.

d. Significant increases in capital expenditures since the base year used to establish the hybrid payment rates. Examples would include major building renovations, major equipment purchases, or a replacement hospital.

e. The addition or deletion of a teaching program.

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. Rate reconsideration requests will be submitted in writing to the DHHS Division of Acute Care Reimbursements and will set forth the

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 fee for service 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

worksheets such as the DSH survey, are subject to audit by the DHHS or its designee. The audited information will be used for future rate calculations, retrospective cost settlements, disproportionate share program requirements, utilization review contractor requirements and other analyses.

I. Hospital Cost Reports

All hospital cost reports will be desk audited in order to determine the SC Medicaid portion of each hospital's cost. This desk-audited data will be used in cost settlement and DSH payment calculations and will be subject to audit.

a. Supplemental worksheets submitted by hospitals for the disproportionate share program will be reviewed for accuracy and reasonableness by DHHS. Beginning with the 2005 DSH period, the DSH program will undergo an audit by an independent auditor. The findings from these audits could result in educational intervention to ensure accurate reporting.

b. As required by Section 1923(j) of the Social Security Act related to auditing and reporting of Disproportionate Share Hospital (DSH) payments, the Medicaid Agency will implement procedures to comply with the DSH hospital payments final rule issued in the December 19, 2008, Federal Register, with effective date of January 19, 2009, to ensure that the hospital specific DSH limits have not been exceeded. Any funds recouped as a result of audits or other corrections shall be redistributed to other eligible hospitals within the state, provided each hospital remains below their hospital specific DSH limit based on the final DSH Audit. After the redistribution of DSH payments recovered is completed no provider can exceed its DSH limit determined based on the final DSH audit. The distribution methodology for eligible DSH hospitals will be as follows:

1. First, SC DSH hospitals with audited hospital specific DSH limits in excess of DSH payments will be identified. However, see section X(C)I)(e)(III)(d) for proper treatment of SCDMH DSH hospitals.

2. Next, the unreimbursed hospital specific DSH limit (i.e. difference between the hospital specific DSH limit and the DSH payment) will be calculated for each hospital and then summed for those hospitals identified in (1) above.

3. Next, each DSH hospital's unreimbursed hospital specific DSH limit as calculated in (2) above will be compared to the sum of the unreimbursed hospital specific DSH limit amounts determined in (2) above to determine the hospital's share of the DSH redistribution amount.

c. 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.

d. Psychiatric Residential Treatment Facility (RTF) Cost Reports.

i. All psychiatric RTF cost reports will be desk reviewed. This information may be used for future rate updates.

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

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

e. Certified Public Expenditures incurred in providing services to Medicaid and individuals with no source of third party insurance.

The South Carolina Medicaid Agency uses the **CMS Form 2552-96** cost report for its Medicaid Program and all state owned/operated governmental psychiatric hospitals operated by the South Carolina Department of Mental Health (SCDMH) must submit this report each year. The Agency will utilize worksheet Series S, B, C, and D-4 to determine the cost of inpatient hospital services (no outpatient hospital services provided by SCDMH hospitals) provided to Medicaid eligibles and individuals with no source of third party insurance to be certified as public expenditures (CPE) from the **CMS Form 2552-96.** This cost report will also be used to determine the cost of Psychiatric Residential Treatment Facility (PRTF) services provided by SCDMH. The Agency will use the procedures outlined below:

Cost of Medicaid

I. Interim Reconciliation of Interim Medicaid Inpatient Hospital Payments:

Upon receipt of the SCDMH hospitals' fiscal year end June 30 cost report, each hospital's interim Medicaid fee for service rate payments and any supplemental payments that may had been made which applied to services provided during the cost reporting period will be reconciled to its CMS Form 2552-96 cost report as filed to the Medicare Fiscal Intermediary (FI) and Medicaid Agency for the respective cost reporting period.

The State will determine each SCDMH hospital's Medicaid routine per diem cost by first summing the inpatient hospital routine service cost centers and dividing this amount by total inpatient hospital days. The routine service costs will be derived from worksheet B, Part I, column 25 (which includes GME cost, if applicable). Total inpatient hospital days and subprovider days (if applicable) will be obtained from Worksheet S-3, Part 1. Any subprovider cost identified as a non inpatient hospital cost (e.g. Psychiatric Residential Treatment Facility (PRTF)) will be excluded from the calculation of the inpatient hospital's routine cost. Next, in order to determine the Medicaid inpatient hospital ancillary service costs, Medicaid covered inpatient ancillary charges obtained from Medicaid worksheet D-4 will be multiplied

by the applicable "cost" cost to charge ratio(s) by ancillary cost center reflected on Worksheet C. Therefore, to determine each hospital's allowable Medicaid inpatient hospital cost, the Medicaid routine per diem cost will be multiplied by covered Medicaid inpatient days to determine allowable Medicaid inpatient hospital routine costs. The Medicaid days are tied to MMIS paid claims data. The Medicaid allowable inpatient hospital routine cost will then be added to the allowable Medicaid inpatient ancillary costs to determine total allowable Medicaid inpatient hospital costs.

During the interim retrospective cost settlement process, the Medicaid inpatient hospital costs as determined above will be compared to Medicaid payments received and applicable (including both fee for service, gross adjustments, third party liability and copayments, if applicable) to services provided during the cost reporting period. The Medicaid days, charges and payments are tied to MMIS paid claims (including gross adjustment payment data). In the event of an underpayment, the Agency will reimburse the provider only the federal portion of the underpayment. In the event of an overpayment, the Agency will recover only the federal portion of the overpayment. Any difference to the reimbursement amount reflected above will be recorded as an adjustment on the CMS 64 report.

Final Reconciliation of Interim Medicaid Inpatient Hospital Payment Rate Post Reporting Year:

Upon issuance of a Final Audit Report by the Agency's audit contractor of the SCDMH hospital cost reports, the Agency will determine each SCDMH hospital's audited Medicaid routine per diem cost by first summing the inpatient hospital routine service cost centers and dividing this amount by total inpatient hospital days. The routine service costs will be derived from worksheet B, Part I, column 25 (which includes GME cost, if applicable). Total inpatient hospital days and subprovider days (if applicable) will be obtained from Worksheet S-3, Part 1. Any subprovider cost identified as a non inpatient hospital cost (e.g. Psychiatric Residential Treatment Facility (PRTF)) will be excluded from the calculation of the inpatient hospital's routine cost. Next, in order to determine the audited Medicaid inpatient hospital ancillary service costs, Medicaid covered inpatient ancillary charges obtained from Medicaid worksheet D-4 will be multiplied by the applicable "cost" cost to charge ratios by ancillary cost center reflected on Worksheet C. Therefore, to determine each hospital's audited Medicaid inpatient hospital cost, the audited Medicaid routine per diem cost will be multiplied by covered Medicaid inpatient days to determine the audited Medicaid inpatient hospital routine costs. The Medicaid days are tied to MMIS paid claims data. The audited Medicaid inpatient hospital routine cost will then be added to the audited Medicaid inpatient ancillary costs to determine total audited Medicaid inpatient hospital costs. The Agency will compare the audited allowable Medicaid inpatient hospital costs against the Medicaid payments received and applicable (including both fee for service, gross adjustments including interim retrospective cost settlements, third party liability and copayments, if applicable) to services provided during the cost reporting period. The Medicaid days, charges and payments that will be used in the final audit

settlement will be tied to MMIS paid claims (including gross adjustment payment data). In the event of an underpayment, the Agency will reimburse the provider only the federal portion of the underpayment. In the event of an overpayment, the Agency will recover only the federal portion of the overpayment. Any difference to the reimbursement amount reflected above will be recorded as an adjustment on the CMS 64 report.

II. Interim Reconciliation of Interim Medicaid Psychiatric Residential Treatment Facility (PRTF) Payments:

Upon receipt of the SCDMH PRTF's fiscal year end June 30 cost report, the PRTF's interim Medicaid fee for service rate payments and any supplemental payments that may had been made which applied to services provided during the cost reporting period will be reconciled to its CMS Form 2552-96 cost report as filed to the Medicaid Agency for the respective cost reporting period.

The State will determine the SCDMH PRTF's Medicaid per diem cost by first identifying the routine cost of the PRTF (identified as a subprovider) in William S Hall's CMS Form 2552-96 cost report. This amount will be derived from worksheet B, Part I, column 25 (which includes GME cost, if applicable). Total PRTF (i.e. subprovider) patient days that will be used in the determination of the PRTF's Medicaid per diem cost will be obtained from Worksheet S-3, Part 1. Next, in order to determine the PRTF's portion of the ancillary service costs, Medicaid covered PRTF ancillary charges obtained from Medicaid worksheet D-4 will be multiplied by the applicable "cost" cost to charge ratio(s) by ancillary cost center reflected on Worksheet C. Therefore, to determine the PRTF's allowable Medicaid cost, the Medicaid PRTF per diem cost will be multiplied by covered Medicaid PRTF days to determine allowable Medicaid PRTF routine costs. The Medicaid days are tied to MMIS paid claims data. The Medicaid allowable PRTF routine cost will then be added to the allowable Medicaid PRTF ancillary costs to determine total allowable Medicaid PRTF costs.

During the interim retrospective cost settlement process, the Medicaid PRTF costs as determined above will be compared to Medicaid payments received and applicable (including both fee for service, gross adjustments, third party liability and copayments, if applicable) to services provided during the cost reporting period. In the event of an underpayment, the Agency will reimburse the provider only the federal portion of the underpayment. In the event of an overpayment, the Agency will recover only the federal portion of the overpayment. Any difference to the reimbursement amount reflected above will be recorded as an adjustment on the CMS 64 report.

Final Reconciliation of Interim Medicaid Psychiatric Residential Treatment Facility (PRTF) Payment Rate Post Reporting Year: Upon issuance of a Final Audit Report by the Agency's audit contractor of the SCDMH hospital/PRTF cost reports, the Agency will determine the SCDMH PRTF's audited Medicaid routine per diem cost by first identifying the PRTF's routine service cost center and dividing this amount by total PRTF patient days. The PRTF routine service cost will be derived from worksheet B, Part I, column 25 (which includes GME cost, if applicable). Total PRTF patient days

will be obtained from Worksheet S-3, Part 1. Next, in order to determine the audited Medicaid PRTF ancillary service costs, Medicaid covered PRTF ancillary charges obtained from Medicaid worksheet D-4 will be multiplied by the applicable "cost" cost to charge ratios by ancillary cost center reflected on Worksheet C. Therefore, to determine the PRTF's audited Medicaid cost, the audited Medicaid PRTF routine per diem cost will be multiplied by covered Medicaid PRTF patient days to determine the audited Medicaid PRTF routine costs. The Medicaid days are tied to MMIS paid claims data. The audited Medicaid PRTF routine cost will then be added to the audited Medicaid PRTF ancillary costs to determine total audited Medicaid PRTF costs. The Agency will compare the audited Medicaid PRTF costs against the Medicaid payments received and applicable (including both fee for service, gross adjustments including interim retrospective cost settlements, third party liability and copayments, if applicable) to services provided during the cost reporting period. The Medicaid days and payments, including claim and gross adjustment payments, that will be used in the final audit settlement will be tied to MMIS paid claims data. In the event of an underpayment, the Agency will reimburse the provider only the federal portion of the underpayment. In the event of an overpayment, the Agency will recover only the federal portion of the overpayment. Any difference to the reimbursement amount reflected above will be recorded as an adjustment on the CMS 64 report.

Cost of the uninsured

III. Calculation of Interim Disproportionate Share Hospital (DSH) Limit:

A base year will be used to calculate the cost of the SC uninsured, Medicaid managed care enrollees, dual (Medicare/Medicaid) eligibles, and Medicaid eligibles who have inpatient hospital services reimbursed by a commercial insurance carrier. The base year will be the SCDMH hospitals fiscal year end beginning two years prior to the reporting year (ex. 2009 data for federal fiscal year (FFY) 2011 DSH payments). Due to Medicaid services within the State for hospitals eligible to certify public expenditures being certified at cost, there will be no uncompensated care for these services. Therefore, the Interim DSH Limit for each SCDMH hospital will be the estimated uncompensated care for inpatient hospital services provided to SC individuals with no source of third party insurance (i.e. uninsured) plus the uncompensated care (including potential surplus) for inpatient hospital services provided to Medicaid managed care enrollees, dual (Medicare/Medicaid) eligibles, and Medicaid eligibles who have inpatient and outpatient hospital services reimbursed by a commercial carrier.

This computation of establishing interim DSH payments funded by CPEs must be performed on an annual basis and in a manner consistent with the instructions below.

a) Using the CMS Form 2552-96 cost report for the fiscal year ending during the fiscal year data being used (ex. 2009 data for FFY 2011 DSH payments), an allowable routine per diem cost will be calculated for each SCDMH hospital for DSH

payment purposes. The state will determine each SCDMH hospital's DSH eligible routine per diem cost by first summing the inpatient hospital routine service cost centers. These amounts will be derived from worksheet B, Part I, column 25 (which includes GME cost, if applicable). Total inpatient hospital days and subprovider days (if applicable) will be obtained from Worksheet S-3, Part 1. Any subprovider cost identified as a non inpatient hospital cost (e.g. Psychiatric Residential Treatment Facility (PRTF)) will be excluded from the calculation of the inpatient hospital's routine cost. Next, in order to determine the DSH eligible inpatient hospital ancillary service costs associated with SC uninsured, Medicaid managed care enrollees, dual (Medicare/Medicaid) eligibles, and Medicaid eligibles who have inpatient hospital services reimbursed by a commercial insurance carrier, covered inpatient ancillary charges by ancillary cost center and payor class obtained from the annual SC Medicaid DSH Survey will be multiplied by the applicable "cost" cost to charge ratio(s) by ancillary cost center reflected on Worksheet C. Therefore, to determine each hospital's DSH eligible allowable inpatient hospital cost, the DSH eligible routine per diem cost will be multiplied by SC DSH eligible inpatient days to determine allowable DSH eligible inpatient hospital routine costs. The DSH eligible days will be obtained from the annual SC Medicaid DSH Survey. The DSH eligible allowable inpatient hospital routine cost will then be added to the DSH eligible allowable inpatient ancillary costs to determine total allowable DSH eligible inpatient hospital costs.

b) The inpatient hospital cost associated with the South Carolina uninsured and Medicaid eligibles as described above will be trended using the CMS Market Basket Index as described in section VII. of Attachment 4.19-A. The trended cost will then be reduced by payments received from uninsured patients as well as payments received on behalf of inpatient hospital services provided to Medicaid eligibles as described above to determine each hospital's estimated maximum amount of uncompensated care costs to be reimbursed during the DSH payment period.

c) The uncompensated care cost as described above will be used in the development of the interim DSH payment amount as described in section VII. of Attachment 4.19-A.

d) Final Reconciliation of Interim Medicaid DSH Payments Post Reporting Year: Upon issuance of a Final Audit Report by the Agency's audit contractor beginning with the October 1, 2010 DSH Payment Program, the Agency will determine each SCDMH hospital's audited DSH eligible routine per diem cost by first summing the inpatient hospital routine service cost centers. These amounts will be derived from worksheet B, Part I, column 25 (which includes GME cost, if applicable). Total inpatient hospital days and subprovider days (if applicable) will be obtained from Worksheet S-3, Part 1. Any subprovider cost identified as a non inpatient hospital cost (e.g. Psychiatric Residential Treatment Facility (PRTF)) will be excluded from the calculation of the inpatient

hospital's routine cost. Next, in order to determine the DSH eligible inpatient hospital audited ancillary service costs associated with the uninsured and Medicaid eligibles (i.e. Medicaid managed care enrollees, dual (Medicare/Medicaid) eligibles, and Medicaid eligibles who have inpatient hospital services reimbursed by a commercial insurance carrier), covered inpatient ancillary charges by ancillary cost center by payor class will be multiplied by the applicable "cost" cost to charge ratio(s) by ancillary cost center reflected on Worksheet C. Therefore, to determine each hospital's audited DSH eligible inpatient hospital cost, the audited DSH eligible routine per diem cost will be multiplied by DSH eligible inpatient hospital days to determine audited DSH eligible inpatient hospital routine costs. The DSH eligible audited inpatient hospital routine cost will then be added to the DSH eligible audited inpatient ancillary costs to determine total audited DSH eligible inpatient hospital costs. The total audited DSH eligible inpatient hospital cost will then be reduced by payments received from uninsured patients as well as payments received on behalf of inpatient hospital services provided to Medicaid eligibles as described above to determine each hospital's audited hospital specific DSH limit for the DSH payment period. The redistribution of DSH payments that will take place beginning with the October 1, 2010 through September 30, 2011 DSH payment period will be described in section IX(C)(1)(b) of Attachment 4.19-A. However, SCDMH DSH hospitals cannot receive any more FFY 2010/2011 DSH payments than the maximum amount allowed under section VII(A)(1)(iv) of Attachment 4.19-A. In the event of a DSH underpayment, the Agency will reimburse the provider only the federal portion of the underpayment. In the event of a DSH overpayment, the Agency will recover only the federal portion of the overpayment.