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State/Territory Name: South Carolina

State Plan Amendment (SPA) #:13-021

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, MD 21244-1850

Financial Management Group

May 28, 2015

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

RE: State Plan Amendment (SPA) SC 13-021

Dear Mr. Soura:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid state plan submitted under transmittal number (TN) 13-021. Effective October 1, 2013 this amendment proposes to revise the payment methodology for inpatient hospital services. Specifically, this amendment proposes to increase the inpatient hospital base rates by two and three quarter (2.75 %) percent and implement retrospective cost settlement for defined rural hospitals and qualified burn intensive care units at one hundred percent of allowable Medicaid cost. Also the swing bed and administrative day rates will be updated.

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, 2013. 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//

Timothy Hill
Director

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: 13-021

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, 2013

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: ($10.7 million x 70.57%).
a. FFY 2014 $ 7,550,990
b. FFY 2015 $ will be revisited next year

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-A Pages 1, 2, 2a, 4, 10, 16, 22, 23, 24, 26a, 26a.1, 26a.2 and 29

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Attachment 4.19-A Pages 1, 2, 2a, 4, 10, 16, 22, 23, 24, 26a, 26a.1, 26a.2 and 29

10. SUBJECT OF AMENDMENT:
Inpatient Hospital Rate Update effective October 1, 2013

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:
Mr. Keck was designated by the Governor to review and approve all State Plans

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

13. TYPED NAME:
Anthony E. Keck

14. TITLE: Director

15. DATE SUBMITTED: November 18, 2013

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:
11/22/13

18. DATE APPROVED: 05-28-15

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
10/01/13

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

21. TYPED NAME:
Timothy Hill

22. TITLE: Director

23. REMARKS: Approved with following changes to block # 8 and 9 as authorized by state agency.

Block #8 changed to read: 4.19-A Pages 1, 2, 2a, 4, 10, 16, 22, 23, 24, 26a 26a.1, 26a.2, 29 26c and 26f.

Block #9 changed to read: 4.19-A Pages 1, 2, 2a, 4, 10, 16, 22, 23, 24, 26a 26a.1, 26a.2, 29 26c and 26f.

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 South Carolina rural acute care hospitals and qualifying burn intensive care unit hospitals as defined in the plan;

2. a prospective reimbursement system for all other acute and non-acute care hospitals providing inpatient hospital services including all long-term psychiatric hospitals;

3. a prospective payment reimbursement system for private and governmental psychiatric residential treatment facilities.

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 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 effective for discharges occurring on or after October 1, 2013:

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 SC Medicaid fee for service claims during its cost reporting period via a statewide per discharge rate.

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, and free standing short-term psychiatric hospitals using a cost target established at 93%) will be based on a prospective payment system. However, Direct Medical Education (DME) costs (including the capital related portion) and Indirect Medical Education (IME) costs associated with interns/residents and allied health alliance training programs will no longer be considered an allowable Medicaid reimbursable cost for out of state border hospitals. The DME and IME cost component of the SC long term acute care hospitals and the SC freestanding short-term psychiatric hospitals associated with interns/residents and allied health alliance training programs will be recognized at eighty-seven.three percent (87.3%) of allowable SC Medicaid inpatient hospital DME costs (including the DME capital related portion) and IME costs during the rate setting process. Effective for discharges occurring on or after October 1, 2013, the November 1, 2012 base rate component of the out of state border general acute care hospitals with SC Medicaid fee for service utilization of at least 200 claims will be increased by 2.75%.

c. Effective for discharges occurring on or after November 1, 2012, all SC general acute care hospitals except those designated as SC critical access hospitals, SC isolated rural and small rural hospitals as defined by Rural/Urban Commuting Area classes, certain SC large rural hospitals as defined by Rural/Urban Commuting Area classes and located in a Health Professional Shortage Area (HPSA) for primary care for total population, certain SC large rural hospitals as defined by Rural/Urban Commuting Area classes with an average of 35 full time equivalent occupied beds or less based upon hospital fiscal year 2008 thru 2011 cost report census data, and qualifying burn intensive care unit hospitals which contract with the SC Medicaid Program will receive prospective payment rates using a cost target established at 93%. However, the DME and IME cost component of these SC general acute care hospitals with interns/residents and allied health alliance programs will be allowed at eighty-seven.three percent (87.3%) of allowable SC Medicaid inpatient hospital DME (including the DME capital related costs) and IME costs during the rate setting process. Effective for discharges occurring on or after October 1, 2013, the November 1, 2012 base rate component of all SC general acute care hospitals except those designated as SC critical access hospitals, SC isolated rural and small rural hospitals as defined by Rural/Urban Commuting Area classes and located in a Health professional Shortage Area (HPSA) for primary care for total population, certain SC large rural hospitals as defined by Rural/Urban Commuting Area classes with an average of 35 full time equivalent occupied beds or less based upon hospital fiscal year 2008 thru 2011 cost report census data, and qualifying burn intensive care unit hospitals which contract with the SC Medicaid Program will be increased by 2.75%.

d. Effective for discharges occurring on or after November 1, 2012, SC general acute care hospitals designated as SC critical access hospitals or those

identified as SC isolated rural and small rural hospitals as defined by Rural/Urban Commuting Area classes will continue to receive retrospective cost settlements that represent ninety-seven percent (97%) of allowable SC Medicaid inpatient costs which includes base, capital, DME and IME costs. Additionally, certain SC large rural hospitals as defined by Rural/Urban Commuting Area classes and are located in a Health Professional Shortage Area (HPSA) for primary care for total population or have an average of 35 full time equivalent occupied beds or less based upon hospital fiscal year 2008 thru 2011 cost report census data will continue to receive ninety-seven percent (97%) of allowable SC Medicaid inpatient costs which includes base, capital, DME and IME costs. Interim prospective payment rates will be calculated using a cost target established at 97%. Effective for discharges occurring on or after October 1, 2013, SC general acute care hospitals designated as SC critical access hospitals, SC isolated rural and small rural hospitals as defined by Rural/Urban Commuting Area classes, certain SC large rural hospitals as defined by Rural/Urban Commuting Area classes and located in a Health professional Shortage Area (HPSA) for primary care for total population, and certain SC large rural hospitals as defined by Rural/Urban Commuting Area classes with an average of 35 full time equivalent occupied beds or less based upon hospital fiscal year 2008 thru 2011 cost report census data will receive retrospective cost settlements that will equal 100% of allowable SC Medicaid inpatient costs which includes base, capital, DME and IME costs. Additionally, for discharges occurring on or after October 1, 2013, the qualifying hospitals identified above will receive a 2.75% increase to their November 1, 2012 interim hospital specific per discharge rate.

e. All qualifying hospitals that employ a burn intensive care unit and contract with the SC Medicaid Program will receive an annual retrospective cost settlement for inpatient services provided to SC Medicaid patients. Effective for discharges occurring on or after November 1, 2012, the retrospective cost settlement amount for qualifying hospitals with a burn intensive care unit will continue to be limited to ninety-seven percent (97%) of allowable SC Medicaid inpatient costs which includes base, capital, DME and IME costs. Interim prospective payment rates will be calculated using a cost target established at 97%. Effective for discharges occurring on or after October 1, 2013, qualifying hospitals that employ a burn intensive care unit and contract with the SC Medicaid Program will receive retrospective cost settlements that will equal 100% of allowable SC Medicaid inpatient costs which includes base, capital, DME and IME costs. Additionally, for discharges occurring on or after October 1, 2013, the qualifying hospital identified above will receive 2.75% increase to their November 1, 2012 interim hospital specific per discharge rate. In order for a hospital to qualify under this scenario, a hospital must:

   a. Be located in South Carolina or within 25 miles of the South Carolina border;

   b. Have a current contract with the South Carolina Medicaid Program; and

   c. Have at least 25 beds in its burn intensive care unit.

f. Effective for services provided on or after October 1, 2012, all SC contracting non-state owned governmental long-term care psychiatric hospitals and all contracting SC long-term psychiatric hospitals owned by the SC Department of Mental Health will receive prospective per diem payment rates.

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

Effective for discharges occurring on and after April 8, 2011, the retrospective cost settlement amount for qualifying hospitals with a burn intensive care unit will be limited to ninety-seven percent (97%) of allowable SC Medicaid inpatient costs. Effective for discharges occurring on and after October 1, 2013, the retrospective cost settlement amount for qualifying hospitals with a burn intensive care unit will be established at one-hundred percent of allowable SC Medicaid inpatient costs.

13. Effective for dates of service on or after October 1, 2011, qualifying hospitals that meet the criteria of Section VI(N) will receive quarterly supplemental enhanced payments for fee-for-service inpatient hospital services.

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 of data used for calculation of payment rates. For the DRG payment system rates effective on and after November 1, 2012, the base year shall be each facility's fiscal year 2011 cost reporting period and incurred inpatient hospital claims for the period October 1, 2011 through August 31, 2012 paid through August 31, 2012. For the freestanding governmental long-term psychiatric hospital rates, the base year shall be each facility's 2010 or 2011 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.

III. Services Included in the Hybrid Payment System

1. Acute Care Hospitals

The DRG payment system rates will include all services provided in an acute inpatient setting except:

a. Professional component, including physician and CRNA services and any other professional fees excluded under Part A Medicare.

b. Ambulance, including neonatal intensive care transport.

2. Psychiatric Residential Treatment Facilities

The per diem reimbursement rate will be the "all-inclusive" rate as defined in Section II, paragraph 30 of this plan.

IV. Data Sources and Preparation of Data for Computation of DRG Payment System Rates

Computation of the October 1, 2011 DRG payment system rates under this plan will require the collection and preparation of the following data elements: per discharge DRG list including relative weights, Medicaid inpatient cost to charge ratios adjusted for April 8, 2011 and July 11, 2011 reimbursement changes, July 1, 2010 through June 30, 2011 incurred inpatient hospital claims with a run out date of August 5, 2011, hospital specific add-ons, case mix index, and an upcode adjustment factor. Computation of the November 1, 2012 payment system rates will require the use of the October 1, 2011 payment rates and the additional data elements: HFY 2011 Medicaid inpatient cost to charge ratios adjusted for the April 8, 2011 and July 11, 2011 reimbursement changes, HFY 2010 audit adjustment factor, and October 1, 2011 through August 31, 2012 incurred inpatient hospital claims with a run out date of August 31, 2012. Computation of the October 1, 2013 payment rates will require the use of the November 1, 2012 payment rates for those qualifying hospitals identified in Section I.C.1 b, c, d and e and the application of a 2.75% trend factor as outlined in each section. All other general acute care hospitals not covered under these sections will continue to receive the November 1, 2012 payment rate for discharges incurred on or after October 1, 2013.

A description of the source documents for the required data elements and the steps necessary for preparing the data for the rate computation described in Section V of this plan is presented in the following subsections.

A. Per Discharge DRG List

The DRG payment system will establish payment based upon a hospital specific and/or statewide average per discharge rate. Effective for discharges incurred on or after November 1, 2012, the Medicaid Agency will determine inpatient hospital claim payments based upon the DRG listing contained within version 28 of the APR-DRG grouper. Hospitals eligible to receive a hospital specific per discharge rate will include all SC general acute care hospitals as well as burn intensive care unit hospitals and qualifying rural hospitals that will continue to receive retrospective cost settlements and out of state border hospitals with SC Medicaid inpatient utilization of at least 200 inpatient claims during its HFY 2011 cost reporting period. Additionally, SC free standing short term psychiatric hospitals and SC long term acute care hospitals, with a minimum SC Medicaid inpatient utilization of at least 10 incurred claims during October 1, 2011 through August 31, 2012, will also receive a hospital specific per discharge rate. All other contracting/enrolled hospitals (i.e. out of state general acute care, new SC general acute care hospitals coming on line after 2011, and all other short term psychiatric and long term acute care hospitals) will receive the statewide average rate. The statewide average rate will exclude DME and IME costs.

c. The Medicaid allowable inpatient cost determined in b. above is reduced by one and a half percent (1.5%) to determine the cost target to be used for each eligible hospital to receive a hospital specific rate. The one and a half percent reduction is applied to take into account the difference between the cost report year and the claims data period.

d. The Medicaid cost target for each hospital determined in c) above will then be compared to each hospital's corresponding Medicaid fee for service claims payments (including co-pay and TPL) paid during the period outlined in b) above to determine the calibration adjustment needed to adjust each hospital's October 1, 2011 hospital specific per discharge rate. For example, if a hospital is a $1,000,000 short of the Medicaid cost target and that facility had $10,000,000 in Medicaid payments, a factor of 1.10 would be applied to its October 1, 2011 Medicaid per discharge rate to determine the November 1, 2012 Medicaid per discharge rate. Conversely, if that same hospital had Medicaid payments of $1,000,000 in excess of the Medicaid cost target, a factor of .90 would be applied to the hospital's October 1, 2011 Medicaid per discharge rate to determine the November 1, 2012 Medicaid per discharge rate.

e. Next, in order to allocate the November 1, 2012 Medicaid per discharge rate for teaching hospitals between the three rate components (i.e. base, DME and IME), the percentage of each component reflected within each teaching hospital's October 1, 2011 per discharge rate will be used to determine the three rate components effective November 1, 2012. Non-teaching hospitals will only have one rate component (i.e. base).

f. For all other general acute care hospitals that did not receive a hospital specific per discharge rate, a statewide per discharge rate was developed by first multiplying the base operating cost component of each hospital receiving a hospital specific per discharge rate by the total number of its discharges used in the November 1, 2012 rate setting (i.e. October 1, 2011 through August 31, 2012 incurred paid claims). Next, the sum of the calculated base operating cost amounts for all hospitals was divided by the sum of the discharges for all hospitals to determine the statewide per discharge rate effective November 1, 2012. Effective for discharges occurring on and after October 1, 2013, new short term psychiatric hospitals that begin to contract with the SC Medicaid Program on and after October 1, 2013 will receive a statewide per discharge rate that will be developed using the November 1, 2012 hospital specific rates of short term psychiatric hospitals currently contracting with the SC Medicaid Program weighted by state fiscal year (SFY) end 2011 discharges of each short term psychiatric hospital receiving payments during SFY 2011.

g. The rate determined above is multiplied by the regular weight for that DRG to calculate the reimbursement for DRG claims.

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.

E. 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 - April 7, 2011	154.67
April 8, 2011 - October 31, 2011	150.03
November 1, 2011 -September 30, 2012	150.53
October 1, 2012 -September 30, 2013	155.88
October 1, 2013 -	162.19

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

F. 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 - April 7, 2011	163.83 (ARM 9.16)
April 8, 2011 - October 31, 2011	158.92 (ARM 8.89)
November 1, 2011 -September 30, 2012	159.42 (ARM 8.89)
October 1, 2012 September 30, 2013	164.77 (ARM 8.89)
October 1, 2013	171.08 (ARM 8.89)

2. Patients who require more complex care services 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 - April 7, 2011	364.00
April 8, 2011. -. September 30, 2011	353.08
October 1, 2011 -	450.00

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

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

G. Payment for One-Day Stay

Reimbursement for one-day stays (except deaths, false labor (565-1 to 565-4), normal deliveries (560-1 to 560-4 and 541-1 to 541-4)) and normal newborns (640-1 to 640-4)) 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.

H. 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 DRG payment system, the per discharge payment rate will be set at the applicable statewide average per discharge rate and adjusted accordingly if a teaching hospital.

b. For private freestanding long-term care psychiatric facilities, payment will be at the statewide average per diem for long term care psychiatric facilities.

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

I. Retrospective Hospital Cost Settlements

Effective for services provided on or after October 1, 2013, 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.

- Effective for discharges occurring on or after October 1, 2013, SC general acute care hospitals designated as SC critical access hospitals or those identified as SC isolated rural and small rural hospitals as defined by Rural/Urban Commuting Area classes will receive retrospective cost settlements that represent one-hundred percent (100%) of allowable SC Medicaid inpatient costs which includes base, capital, DME and IME costs. Additionally, certain SC large rural hospitals as defined by Rural/Urban Commuting Area classes and are located in a Health Professional Shortage Area (HPSA) for primary care for total population will receive one-hundred percent (100%) of allowable SC Medicaid inpatient costs which includes base, capital, DME and IME costs.

- Effective for discharges incurred on or after October 1, 2013, SC large rural hospitals as defined by Rural/Urban Commuting Area classes with an average of 35 full time equivalent occupied beds or less based upon hospital fiscal year 2008 thru 2011 cost report census data will receive retrospective cost settlements that represent one-hundred percent (100%) of allowable SC Medicaid costs which include base, capital, DME and IME costs.

- Effective for discharges occurring on or after October 1, 2013, the retrospective cost settlement amount for qualifying hospitals with a burn intensive care unit will be limited to one-hundred percent (100%) of allowable SC Medicaid inpatient costs which includes base, capital, DME and IME costs.

N. Upper Payment Limit Calculation

I. Non-State Owned Governmental and Private Inpatient Hospital Service Providers

The following methodology is used to estimate the upper payment limit applicable to non-state owned governmental and privately owned or operated inpatient hospitals (i.e. for profit and non-governmental nonprofit facilities):

The most recent HFY 2012 2552-10 cost report serves as the base year cost report to be used for Medicaid UPL calculations. In order to determine the Medicare allowable cost using Medicare allowable cost principles (i.e. upper payment limit), the SCDHHS employs the following process:

(1) Covered Medicaid inpatient hospital routine charges are determined by multiplying covered Medicaid inpatient hospital routine billed charges by the ratio of Medicaid Covered days to Medicaid billed days. Data source - Summary MARS inpatient hospital report.

(2) Covered Medicaid inpatient hospital ancillary charges are determined by multiplying covered Medicaid inpatient hospital ancillary billed charges by the ratio of Medicaid Covered days to Medicaid billed days. Data source - Summary MARS inpatient hospital report.

(3) Medicaid covered inpatient hospital routine cost is determined by multiplying Medicaid routine days as identified on worksheet S-3, column 7, lines 1, 8 thru 13 and 16 thru 17 by the routine cost per diems determined by the amounts reflected on worksheet B Part I, column 24, lines 30 thru 40 divided by total days of each routine cost center reflected on worksheet S-3, column 8, lines 1 thru 18. Data source - HFY 2552-10 cost report.

(4) Medicaid covered inpatient hospital ancillary cost is determined by multiplying covered Medicaid inpatient hospital ancillary charges as identified on worksheet D-3, column 2, lines 50 thru 117 by the ancillary cost to charge ratios as reflected on worksheet C, column 8, lines 50 thru 117. Data source - HFY 2552-10 cost report.

(5) Total Medicaid inpatient hospital cost is determined by combining Medicaid covered inpatient hospital routine cost (step 3) with covered Medicaid inpatient hospital ancillary cost (step 4). The total Medicaid inpatient hospital cost is then trended using the mid-year to mid-year inflation method and the Medicare Inpatient Hospital Market Basket Index rate (prior to productivity adjustment) for FY 12, FY 13, and FY 14 in order to trend the base year cost (HFY 2012) to the Medicaid rate period October 1, 2013 through September 30, 2014.

(6) Total base year Medicaid inpatient hospital revenue is derived from each hospital's Summary MARS report based upon each hospital's cost reporting period.

(7) Next, to account for the changes in Medicaid payment/rate updates since the base year, the Department applied the percentage increase/(decrease) change in the November 1, 2012 per discharge rates to the annual base year Medicaid inpatient hospital revenue reflected in step (6) above.

(8) Next, to account for the changes in the Medicaid payment/rate updates effective October 1, 2013, the annual estimated Medicaid inpatient revenue as determined in step (7) was multiplied by the hospital specific increase effective October 1, 2013 to determine projected Medicaid revenue for the period October 1, 2013 through September 30, 2014. For hospitals that continue to receive retrospective cost settlements at 100% of allowable costs on and after October 1, 2013, the estimated revenue for the October 1, 2013 through September 30, 2014 payment period equals the trended inflated cost as described in step (5).

(9) The Medicaid UPL compliance check is determined for each class by comparing the aggregate amounts as determined in (5) above to ensure that projected Medicaid inpatient hospital cost is equal to or greater than projected Medicaid inpatient hospital rate expenditures in step (7). In the event that aggregate Medicaid inpatient hospital rate expenditures exceed aggregate Medicaid hospital cost, the Medicaid per discharge rate for each facility will be limited to the Medicaid cost based rate as determined in (8) above

II. State Owned Governmental Psychiatric Hospital Services

The following methodology is used to estimate the upper payment limit applicable to state owned governmental inpatient psychiatric hospitals:

The most recent HFY 2012 2552-10 cost report serves as the base year cost report to be used for Medicaid rate setting and UPL calculations. In order to determine the Medicare allowable cost using Medicare allowable cost principles (i.e. upper payment limit), the SCDHHS employs the following process:

(1) Medicaid covered inpatient hospital routine cost is determined by multiplying Medicaid routine days as identified on worksheet S-3, column 7, lines 1 and 8 thru 13 by the routine cost per diems determined by the amounts reflected on worksheet B Part I, column 24, lines 30 thru 40 divided by total days of each routine cost center reflected on worksheet S-3, column 8, lines 1 thru 13. Data source - HFY 2552-10 cost report.

(2) Medicaid covered inpatient hospital ancillary cost is determined by multiplying Medicaid routine days as identified on worksheet S-3, column 7, lines 1 and 8 thru 13 by the sum of the ancillary cost centers determined by the amounts reflected on worksheet B Part I, column 24, lines 50 thru 117 divided by total days of all routine cost centers reflected on worksheet S-3, column 8, lines 1 thru 13. Data source - HFY 2552-10 cost report.

(3) Total Medicaid inpatient hospital cost is determined by combining Medicaid covered inpatient hospital routine cost (step 1) with covered Medicaid inpatient hospital ancillary cost (step 2). The total Medicaid inpatient hospital cost is then trended using the mid-year to mid-year inflation method and the Medicare Inpatient Hospital Market Basket Index rate (prior to productivity adjustment) for FY 12, FY 13, and FY 14 in order to trend the base year cost (HFY 2012) to the Medicaid rate period October 1, 2013 through September 30, 2014.

(4) Total base year Medicaid inpatient hospital revenue is derived from each hospital's DataProbe (SCDHHS Decision Support System) Summary report based upon each hospital's cost reporting period.

(5) Total projected Medicaid inpatient hospital revenue is determined by taking the October 1, 2012 Medicaid per diem rate multiplied by the HFY 2012 Medicaid days as identified via the DataProbe report.

(6) The Medicaid UPL compliance check is determined for this class by comparing the aggregate amounts as determined in (3) above to ensure that projected Medicaid inpatient hospital cost is equal to or greater than projected Medicaid inpatient hospital rate expenditures in step 5. In the event that aggregate Medicaid inpatient hospital rate expenditures exceed aggregate Medicaid hospital cost, the Medicaid per discharge rate for each facility will be limited to the Medicaid cost based rate as determined in (3) above.

that are not considered an inpatient or outpatient hospital service (e.g. home health, ambulance, etc.) will not be reflected within these calculations.

(2) Covered Medicaid inpatient hospital days used in the UPL calculation are reconciled to the SC MMIS.

(3) Covered Medicaid inpatient hospital ancillary charges used in the UPL calculations are those that are provider reported and are subject to reconciliation to the SC MMIS if a variance of 3%+ exists between provider reported inpatient ancillary charges versus SC MMIS reported inpatient ancillary charges.

(4) To determine the UPL gap that will be used to make supplemental payments the amount determined for each hospital in step 1 above will be subtracted from the amount paid to each hospital adjusted for any changes in payment rates during the payment year. The aggregate gap amount for each group of hospitals (private and non-state government) will serve as the basis for the supplemental payments to the private and non-state government hospitals. Furthermore, the supplemental payments available under this section cannot exceed the difference between total Medicaid covered inpatient hospital charges and total allowable Medicaid inpatient revenue received by each hospital eligible to receive UPL reimbursement under this section.

(5) For payments made on and after October 1, 2012, base year cost will be trended accordingly using CMS Market Basket rates. For payments made on and after October 1, 2013, base year cost will be trended using the midpoint to midpoint methodology and the use of the Global Insight 2010 Based CMS Hospital Prospective Reimbursement Quarterly Market Basket Indexes (1st Qtr. 2014 Edition). Medicaid base year revenue will be adjusted accordingly to reflect changes made to SC Medicaid inpatient hospital reimbursement since October 1, 2012. For subsequent fiscal years, data utilized from the HFY 2552-10 cost report and HFY Summary MARS Report will be no older than 2 years prior to the projected spending year.

the Medicaid worksheet D-3, column 2, lines 50 through 112 by the ancillary cost to charge ratios as reflected on worksheet C, column 9, lines 50 through 112. Any ancillary services reflected within these lines (i.e. 50 through 112) that are not considered an inpatient or outpatient hospital service (e.g. home health, ambulance, etc.) will not be reflected within these calculations.

(2) Covered Medicaid inpatient hospital days used in the UPL calculation are reconciled to the SC MMIS.

(3) Covered Medicaid inpatient hospital ancillary charges used in the UPL calculations are those that are provider reported and are subject to reconciliation to the SC MMIS if a variance of 3%+ exists between provider reported inpatient ancillary charges versus SC MMIS reported inpatient ancillary charges.

(4) To determine the UPL gap that will be used to make supplemental payments the amount determined for each hospital in step 1 above will be subtracted from the amount paid to each hospital adjusted for any changes in payment rates during the payment year. The aggregate gap amount for each group of hospitals (private and non-state government) will serve as the basis for the supplemental payments to the private and non-state government hospitals. Furthermore, the supplemental payments available under this section cannot exceed the difference between total Medicaid covered inpatient hospital charges and total allowable Medicaid inpatient revenue received by each hospital eligible to receive UPL reimbursement under this section.

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VIII. Retrospective Hospital Cost Settlement Methodology For Qualifying Rural Hospitals and Qualifying Burn Intensive Care Unit Hospital:

The following methodology describes the inpatient hospital cost settlement process for qualifying hospitals effective for services provided on or after October 1, 2013.

A. A cost-to-charge ratio will be calculated for Medicaid inpatient claims. This ratio will be calculated using cost from worksheet B part I, charges from worksheet C, Medicaid and total days from worksheet S-3 and Medicaid settlement data from worksheet D-3. For each routine cost center, a per diem cost will be determined by dividing the allowable cost as reported on worksheet B part I (after removing swing bed cost and reclassifying observation cost) by total days as reported on worksheet S-3. This per diem will then be multiplied by Medicaid days as reported on worksheet S-3 in order to determine Medicaid routine cost. For ancillary cost centers, a cost-to-charge ratio will be calculated by dividing cost as reported on worksheet B part I by total charges from worksheet C. Medicaid cost for each ancillary cost center will be determined by multiplying this ratio by Medicaid charges as reported on worksheet D-3. The cost-to-charge ratio will be determined by dividing the sum of the calculated Medicaid routine and ancillary cost by the sum of the Medicaid charges as reported on worksheet E-3 (routine) and D-3 (ancillary). Charges not covered by the hospital payment system, such as CRNA and ambulance, must be excluded from this calculation.

Total allowable Medicaid cost will be determined at the time of cost settlement by multiplying the cost-to-charge ratio as calculated in A above, by Medicaid allowed charges. Medicaid allowed charges will be determined by multiplying covered Medicaid billed charges by the ratio of covered to billed days. (This will remove charges for patients that are not covered for their entire stay).