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State/Territory Name: South Carolina

State Plan Amendment (SPA) #: 13-023

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

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

RE: State Plan Amendment (SPA) SC 13-023

Dear Mr. Soura:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid state plan submitted under transmittal number (TN) 13-023. Effective November 1, 2013 this amendment proposes to revise the payment methodology for long term psychiatric hospitals, nursing homes and Psychiatric Residential Treatment Facility services. Specifically, this amendment proposes to update the base year cost reports to 2012 used to determine the prospective payment rates for fiscal year end 2014. The provider's 2012 cost will be trended to the rate year 2014 using the Centers for Medicare and Medicaid market basket rates.

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 November 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: 13-023

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
November 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 447 Subpart C

7. FEDERAL BUDGET IMPACT:
a. FFY 2014 $ 2,070,053
b. FFY 2015 $ 2,258,240

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-A, pages 4, 12, 15, 17, 19,
Attachment 4.19-D, page 23

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Attachment 4.19-A, pages 4, 12, 15, 17, 19
Attachment 4.19-D, page 23

10. SUBJECT OF AMENDMENT:
South Carolina Department of Mental Health (SCDMH) Nursing Home, Long Term Psychiatric Hospital and Psychiatric Residential Treatment Facilities rate updates effective November 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:
December 12, 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:
12/28/13

18. DATE APPROVED: 08/04/15

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
11/01/13

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

21. TYPED NAME:
Timothy Hill

22. TITLE: Director

23. REMARKS:

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

6. Payment for services provided in private freestanding long-term care psychiatric facilities shall be based on the statewide average per diem for psychiatric long-term care provided by governmental providers.

7. The payments determined under both payment methods, the DRG payment system for general acute care hospitals, including acute psychiatric and rehabilitation units, long term acute care hospitals, 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 describes hospital cost settlements and Section VII describes Disproportionate Share Hospital payments.

8. Special payment provisions, as provided in Section VI A of this plan, will be available under the DRG payment system for discharges which are atypical in terms of costs of services provided during the stay. These cases will be referred to as outliers. Special payment policies, as specified in Section VI B and C 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.

9. 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.

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

11. 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.

12. 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.

    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 Sections VI(N) or VI(O) 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. Audit Adjustment Factor - An adjustment factor used in the hospital specific Medicaid inpatient hospital rate setting process based upon the results of the HFY 2010 final audit report issued by the SC Medicaid audit contractor.

4. Base Year - The fiscal year used for calculation of payment rates. For the hospital specific inpatient payment rates effective on and after November 1, 2012, the base year shall be each facility's 2011 fiscal year. For the freestanding governmental long-term psychiatric hospital rates, the base year shall be each facility's 2010 (state owned governmental) or 2011 (non-state owned governmental) fiscal year. Effective for services incurred on or after November 1, 2013, the base year used to calculate each freestanding governmental long-term psychiatric hospital rate will be each facility's 2012 fiscal year cost report.

5. 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.

6. Calibration Adjustment - An adjustment that is used in the Medicaid inpatient hospital rate setting process that takes into account changes in hospital specific cost and hospital case mix and has the effect of increasing or decreasing hospital specific per discharge rates. This factor is also referred to as a "Rate Adjustment Factor".

7. 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.

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

9. Complex Care Services - Those services rendered to patients that meet the South Carolina level of care criteria for long term care and have multiple needs (i.e. two or more) which fall within the highest ranges of disabilities in the criteria.

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

3. The SC Medicaid inpatient cost-to-charge ratio, which reflects 100% of allowable Medicaid costs (including DME and IME) will be determined by taking the sum of the SC Medicaid routine service costs and inpatient ancillary costs and dividing this amount by the sum of the SC Medicaid covered routine service charges and inpatient covered ancillary charges.

4. Next, for non teaching hospitals, the inpatient hospital cost to charge ratio as determined in step 3. above will be reduced by either the April 8, 2011 payment reduction amount (i.e.3% of all costs) or by the July 11, 2011 payment reduction amount (i.e. 7% of all costs) as defined under Section I. (C), Overview of Reimbursement Principles, paragraphs (1) b., c., d., and e.

5. Next, for teaching hospitals as defined by the state plan, the inpatient hospital cost to charge ratio as determined in step 3. above will need to be broken out into two inpatient hospital cost to charge ratios consisting of base operating costs (including capital) and Graduate Medical Education costs (including Direct and Indirect). Therefore, Direct Medical Education costs as reported on worksheet B Part I are identified and removed from total allowable facility costs as reported under worksheet B, Part I, column 24 to determine base operating costs. Next, to determine the amount of Indirect Medical Education costs of teaching hospitals with an intern and resident training program, the base operating costs previously described will be multiplied by the Indirect Medical Education formula described in Section II 16. The amount of Indirect Medical Education costs as determined in this computation will be removed from base operating costs and then added to the amount of Direct Medical Education costs to determine Graduate Medical Education costs. Next, routine per diems and ancillary cost to charge ratios will be developed for both base operating costs and Graduate Medical Education costs based upon the methodology previously described in this section and multiplied by covered Medicaid inpatient hospital days and covered Medicaid inpatient ancillary charges to determine two Medicaid cost pools - one for base operating costs and one for Graduate Medical Education costs. Next, in order to determine the Medicaid allowable inpatient hospital cost, the individual cost pools will be reduced by either the April 8, 2011 payment reduction amount (i.e. 3% of all costs) or by the July 11, 2011 payment reduction amount (i.e. 7% on base and 12.7% or 100% on Graduate Medical Education costs) as defined under Section I. (C), Overview of Reimbursement Principles, paragraphs (1) b., c., d., and e. Finally, the two adjusted Medicaid cost pools will be summed and divided by total Medicaid inpatient hospital covered charges to determine the Medicaid inpatient hospital cost to charge ratio for use in the November 1, 2012 rate setting prior to the application of the HFY 2010 audit adjustment factor.

6. Finally, cost to charge ratios determined in steps 4 and 5 will be adjusted upward or downward by the HFY 2010 audit adjustment factor. The HFY 2010 audit adjustment factor is determined by taking the audited HFY 2010 inpatient cost to charge ratio and dividing it by the interim HFY 2010 inpatient cost to charge ratio.

In a separate computation, a cost per day will be determined for prospective reimbursement for all free-standing long-term care psychiatric facilities based on 2010 or 2011 cost report data for services provided on or after October 1, 2012. Effective for services incurred on or after November 1, 2013, the base year used to calculate each freestanding governmental long-term psychiatric hospital rate will be each facility's 2012 fiscal year.

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 the period July 1, 2010 through June 30, 2011 by the DRG relative weight, summing these amounts and dividing by the sum of the total per case discharges. Version 28 of the APR-DRG grouper and the corresponding national relative weights (released in October 2010) were used in the calculation of the case mix index for each hospital.

F. Psychiatric Residential Treatment Facility Costs

Psychiatric residential treatment facility per diem reimbursement rates, effective for dates of service beginning on or after 09/01/98, 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. Effective for services provided on or after October 1, 2012 both state owned and non-state owned governmental PRTFs will receive prospective reimbursement based upon its FY 2010 cost reporting period trended to the October 1, 2012 payment period. Effective for services provided on or after November 1, 2013, the SCDMH state owned PRTF's prospective payment rate will be based upon its FY 2012 cost reporting period trended to the November 1, 2013 payment period.

V. Reimbursement Rates

A. Inpatient Hospital

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

1. Hospital Specific Per Discharge Rates Effective November 1, 2012:

First, the following methodology is employed in the computation of the hospital specific per discharge rates effective November 1, 2012:

a. The hospital specific per discharge rates will continue to be calculated so that DRG based payments approximate the Department's specified percent of allowable Medicaid costs for each eligible hospital as described under section VI.B.4 and 5.

b. The adjusted hospital fiscal year 2011 Medicaid inpatient hospital cost to charge ratio of each hospital, as described in Section IV. (B) (4) (5) (6), is multiplied by each hospital's Medicaid inpatient hospital allowed charges based upon discharges incurred during the period October 1, 2011 through August 31, 2012. Medicaid inpatient hospital allowed charges will be determined by multiplying covered Medicaid billed charges by the ratio of covered to billed days. This adjustment removes charges for patients that are not Medicaid covered for their entire stay.

2. Per Diem Prospective Payment Rate - Long-Term Psychiatric Hospitals Effective November 1, 2013.

Only free-standing governmental long-term care psychiatric hospitals are included in this computation.

a) Total allowable Medicaid costs are determined for each governmental long term psychiatric hospital using its fiscal year 2012 Medicaid cost report. Allowable costs would include both routine and ancillary services covered by the long term psychiatric hospital.

b) Next, total patient days incurred by each hospital during its cost reporting period were obtained from each provider's Medicaid cost report.

c) Next, in order to determine the per diem cost for each governmental long term psychiatric hospital, total allowable Medicaid reimbursable costs for each provider is divided by the number of patient days incurred by the provider to arrive at its per diem cost.

d) Finally, in order to trend the governmental long term psychiatric hospitals base year per diem cost (i.e. July 1, 2011 through June 30, 2012 to the payment period (i.e. November 1, 2013 through September 30, 2014) the agency employed the use of the full CMS Market Basket Rates for Inpatient Psychiatric Facilities to determine the trend rate of 5.37% (1.027 x 1.026)-1.

RY 2013- 2.7%
RY 2014- 2.6%

e) For private long term psychiatric hospitals that do not receive a hospital specific per diem rate, a statewide per diem rate will be developed by first multiplying the governmental long term psychiatric hospitals per diem rate by the Medicaid patient days incurred during its base year cost reporting period. Next, the sum of the Medicaid allowable cost amounts for all governmental long term psychiatric hospitals was divided by the sum of the incurred Medicaid patient days to determine the statewide per diem rate to be reimbursed to private long term psychiatric hospitals effective November 1, 2013.

the 1997 cost reporting period. These add-ons will be subject to an occupancy adjustment, if applicable, and will be inflated from the period the cost was incurred.

2. State Government Owned and Operated Facility Rate

   Effective for services provided on or after November 1, 2013, the prospective per diem rate will be determined in a two-step process. First, total allowable Medicaid cost will be divided by total actual patient days based upon the FY 2012 Medicaid cost report. No occupancy adjustment factor will be applied. Next, the FY 2012 per diem cost will then be trended forward to the November 1, 2013 through September 30, 2014 payment period using the trend rate of 5.37% (1.027 X 1.026)-1 based upon the use of the 2013 and 2014 full Medicare I/P Psych Hospital Market Basket Rates (2.7% and 2.6% to determine the prospective per diem rate.

3. Non-State Government Owned and Operated Facility Rate

   Effective for services provided on or after October 1, 2012, the prospective per diem rate will be determined in a two-step process. First, 97% of total allowable Medicaid cost will be divided by total actual patient days based upon the FY 2010 Medicaid cost report. No occupancy adjustment factor will be applied. Next, the FY 2010 per diem cost will then be trended forward to the midpoint of the October 1, 2012 through September 30, 2013 payment period using the midpoint to midpoint methodology and the 2010 Medicare I/P Psych Hospital Market Basket Rate (2.10%) to determine the prospective per diem rate.

4. New Facility Rate

   RTFs enrolled in the SCDHHS Medicaid program subsequent to the 1997 base year will be reimbursed the statewide average RTF rate.

VI. Special Payment Provisions

A. Payment for Outlier Cases - Per Discharge DRG Cases

1. Payments in addition to the base DRG reimbursement are available to a facility for covered inpatient services provided to a Medicaid recipient if the following conditions are met.

   a. The hospital's adjusted cost for a claim exceeds the sum of the DRG threshold and DRG reimbursement. For hospitals which receive its own hospital specific per discharge rate, the hospital's adjusted cost is derived by applying the adjusted hospital specific cost to charge ratio used in the November 1, 2012 rate setting to the hospital's allowed claim charges. For hospitals that receive the statewide average per discharge rate, the hospital's adjusted cost is derived by applying the adjusted statewide cost to charge ratio of .2754 effective November 1, 2012.

   b. The cost outlier thresholds were calculated using the following methodology:
      - Inpatient hospital claims with a discharge date incurred during July 1, 2009 through June 30, 2010 served as the basis for the cost outlier threshold calculations.
      - Calculate the average cost and standard deviation for each DRG.
      - If a DRG has 25 or more stays, set the initial cost outlier threshold at the average cost plus two standard deviations.
      - For DRGs with 25 or more stays, calculate the median ratio of the calculated threshold to the average cost. The result from this dataset is 2.30.

2. Reimbursement Methodology. Each qualifying hospital shall receive quarterly supplemental enhanced payments for the inpatient services rendered during the quarter. In addition to the limitations resulting from the application of the upper payment limit for hospitals reflected in 42 C.F.R. 447.272(a)-(b), annual supplemental enhanced payments to each qualifying hospital as described below, in any Medicaid State Plan rate year shall be limited to the lesser of:

   a. the difference between the hospital's Medicaid inpatient covered charges and Medicaid payments the hospital receives for services processed for fee-for-service Medicaid recipients during the Medicaid State Plan rate year, including any Medicaid inpatient cost settlement the hospital receives for the Medicaid State Plan rate year under Section VI(I) of the state plan; or

   b. for hospitals participating in the Medicaid Disproportionate Share Hospital (DSH) Program, the difference between the hospital's hospital specific DSH limit, as defined in Section VII of the state plan, and the hospital's DSH payments during the Medicaid State Plan rate year.

   c. In the event the payment limitations described in subsections a. or b. exceed the aggregate annual upper payment limit for non-state government operated hospitals, each qualifying hospital's payment will be proportionately reduced to maintain compliance with the aggregate annual upper payment limit for non-state government operated hospitals.

3. UPL Calculation for Supplemental Enhanced Payment

   The following methodology is used to determine the maximum supplemental enhanced payments for qualifying 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 used to establish the maximum supplemental enhanced payments. In order to determine the maximum payments available, the following methodology is employed:

      (1) The inpatient hospital routine and ancillary cost is determined as follows: Medicaid inpatient routine cost is determined by multiplying Medicaid covered days from the SC MMIS and reconciled to worksheet S-3, Part I, column 7, Lines 1, 8 through 13 and 16 through 17 by the routine cost per diems determined by the amounts reflected on worksheet B, Part I, column 24, lines 30 through 43 divided by total days of each routine cost center reflected on worksheet S-3, column 8, lines 1 through 18. Medicaid inpatient hospital ancillary cost is determined by multiplying covered Medicaid inpatient hospital covered ancillary charges reconciled to the SC MMIS and identified on 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.

(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.

ii. county based on the hospital's Core Based Statistical Area in the Centers for Medicare and Medicaid May 2013 Public Use File.

2. Reimbursement Methodology. Each qualifying hospital shall receive quarterly supplemental enhanced payments for the inpatient services rendered during the quarter. In addition to the limitations resulting from the application of the upper payment limit for hospitals reflected in 42 C.F.R. 447.272(a)-(b), annual supplemental enhanced payments to each qualifying hospital in any Medicaid State Plan rate year shall be limited to the lesser of:

a. the difference between the hospital's Medicaid inpatient covered charges and Medicaid payments the hospital receives for services processed for fee-for-service Medicaid recipients during the Medicaid State Plan rate year, including any Medicaid inpatient cost settlement the hospital receives for the Medicaid State Plan rate year under Section VI(I) of the state plan; or

b. for hospitals participating in the Medicaid Disproportionate Share Hospital (DSH) Program, the difference between the hospital's hospital specific DSH limit, as defined in Section VII of the state plan, and the hospital's DSH payments during the Medicaid State Plan rate year.

c. In the event the payment limitations described in subsections a. or b. exceed the aggregate annual upper payment limit for private hospitals, each qualifying hospital's payment will be proportionately reduced to maintain compliance with the aggregate annual upper payment limit for private hospitals.

3. UPL Calculation for Supplemental Enhanced Payment

The following methodology is used to determine the maximum supplemental enhanced payments for qualifying 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 used to establish the maximum supplemental enhanced payments. In order to determine the maximum payments available, the following methodology is employed:

(1) The inpatient hospital routine and ancillary cost is determined as follows: Medicaid inpatient routine cost is determined by multiplying Medicaid covered days from the SC MMIS and reconciled to worksheet S-3, Part I, column 7, Lines 1, 8 through 13 and 16 through 17 by the routine cost per diems determined by the amounts reflected on worksheet B, Part I, column 24, lines 30 through 43 divided by total days of each routine cost center reflected on worksheet S-3, column 8, lines 1 through 18. Medicaid inpatient hospital ancillary cost is determined by multiplying covered Medicaid inpatient hospital covered ancillary charges reconciled to the SC MMIS and identified on

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.

(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.

This report will be due within ninety (90) days after the end of the period of operation. Once new ownership or the prior owner begins operation of the facility, reimbursement will be determined as previously described for a new owner under paragraph E (2).

F. Payment for State Government Nursing Facilities and Institutions for Mental Diseases

Effective November 1, 2013, each state owned nursing facility owned and/or operated by the SC Department of Mental Health will receive a prospective payment rate based upon each facility's fiscal year 2012 cost report. Allowable cost will be defined in accordance with the Provider Reimbursement Manual HIM-15. Allowable costs will include all physician costs except for those physician costs that relate to the provision of professional services. The total allowable Medicaid reimbursable costs of each nursing facility will be divided by the total number of actual patient days served during the cost reporting period to determine the base year Medicaid per diem cost. In order to trend the base year Medicaid per diem cost to the payment period (November 1, 2013 - September 30, 2014), the agency will employ the use of a trend factor of 4.86% ((1.025 x 1.023)-1) based upon the use of the full CMS Skilled Nursing Facility PPS Market Based rate for fiscal years 2013 and 2014 (2.5% and 2.3%).

The Medicaid Agency will not pay more than the provider's customary charge except governmental facilities that provide services free or at a nominal charge. Reimbursement to governmental facilities will be limited in accordance with 42 CFR §447.271 (b).

G. Payment Determination for ICF/IID's

1. All ICF/IID's shall apply the cost finding methods specified under 42 CFR 413.24(d) to its allowable costs for the cost reporting year under the South Carolina State Plan. ICF/IID facilities will not be subject to the allowable cost definitions R (A) through R (K) as defined in the plan.

2. All State owned/operated ICF/IID's are required to report costs on the Medicare Cost Reporting Form 2552. For cost reporting periods beginning on or after July 1, 1986, all other ICF/IID's which are not operated by the State (S.C. Department of Disabilities and Special Needs) will file annual financial and statistical report forms supplied by the Medicaid Agency. All cost reports must be filed with the Medicaid Agency within one hundred twenty (120) days from close of each fiscal year.

Effective October 1, 2012, all ICF/IID facilities will receive a prospective payment rate based upon each facility's fiscal year 2010 cost report. Allowable cost will be defined in accordance with the Provider Reimbursement Manual HIM-15. The total allowable Medicaid reimbursable costs of each ICF/IID will be divided by the total number of actual patient days served during the cost reporting period to determine the base year Medicaid per diem cost. In order to trend the base year Medicaid per diem cost to the payment period (October 1, 2012 - September 30, 2013), the agency will employ the use of the midpoint to midpoint methodology and the use of the CMS Skilled Nursing Facility PPS Market Based rate for fiscal year 2010 (2.2%).

Items of expense incurred by the ICF/IID facility in providing care are allowable costs for inclusion in the facility's cost report. These allowable costs are defined as items of expense which the provider may incur in meeting the definition

of intermediate care or any expenses incurred in complying with state licensing or federal certification requirements.