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State/Territory Name: South Carolina

State Plan Amendment (SPA) #:13-024

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

June 8, 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 13-024

Dear Mr. Soura:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid state plan submitted under transmittal number (TN) 13-024. Effective October 1, 2013 this amendment proposes to revise the payment methodology for inpatient hospital services. Specifically, this amendment proposes to update the base year cost reports used to determine the interim disproportionate share hospital payments (DSH) payments to fiscal year end 2012; trend cost data to the payment year; implement a healthy outcomes initiative program (HOP) to better manage chronically ill patients; reduce hospital base DSH payment by 10% if they do not participate in the HOP and redistribute this amount to hospital that participate; create a $20.0 million DSH pool for rural hospitals that participate in the HOP; and require hospitals to submit claims level detail for all uninsured individuals services eligible for DSH payments.

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: 13-024

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:
a. FFY 2014 $ 5,387,629
b. FFY 2015 $

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-A, pages 27, 28, 28a, 28a.1, 28a.2 (new page), 29 & 33

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Attachment 4.19-A, pages 27, 28, 28a, 28a.1, 29, 29a (deleted; combined language on page 29) & 33

10. SUBJECT OF AMENDMENT:
Disproportionate Share Hospitals (DSH)

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 20, 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: 06-08-15

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:

FORM HCFA-179 (07-92)

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 2014 interim DSH payments, qualification data will be based upon each hospital's fiscal year 2012 cost reporting period.

1. Effective for the October 1, 2013 - September 30, 2014 DSH payment period, 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 all (i.e. SC and out-of-state) uninsured patients, all Medicaid fee for service patients, all Medicaid managed care patients (including PACE Program participants), SC dual (Medicare/Medicaid) eligible patients, and all 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 fifty percent (50%) of the unreimbursed hospital cost for SC uninsured patients, SC Medicaid fee for service 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 SC non-general acute care hospitals contracting with the SC Medicaid Program will equal to fifty percent (50%) of the unreimbursed hospital cost for all (i.e. SC and out-of-state) uninsured patients, all Medicaid fee for service patients, all Medicaid managed care patients (including PACE Program participants), SC dual (Medicare/Medicaid) eligible patients, and all 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 Myers and Stauffer) 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'' merged into the Medicaid Managed Care Program effective October 1, 2010 and thus its costs can be included in the calculation of the interim hospital specific DSH limit.

Except for the SC Department of Mental Health (SCDMH) hospitals, for FFY 2014, 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, Medicaid fee for service, Medicaid MCO enrollees, 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 2012 cost reporting period charges for each group listed

above and multiplying that by the hospital's applicable FY 2012 unadjusted inpatient and outpatient hospital cost to charge ratios (i.e. Medicaid and Medicare) 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, 2012 using the applicable CMS Market Basket Index described in (A)(4) 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 all uninsured patients, all Medicaid fee for service, all dual eligibles, all Medicaid eligibles who have inpatient and outpatient hospital services reimbursed by a commercial carrier, and all Medicaid managed care patients to determine the total unreimbursed cost for each DSH hospital. Out of state border DSH qualifying hospitals and SC non-general acute care DSH qualifying hospitals will only report revenue received from SC residents. However, because of the Medicaid fee for service payment increase effective October 1, 2013, HFY 2012 Medicaid Managed Care Payments and Medicaid payments will be increased appropriately for each hospital based upon its specific payment increase effective October 1, 2013.

ii) For FFY 2014, each SCDMH hospital's interim hospital specific DSH limit will be calculated using FYE June 30, 2012 cost report data for all of its Medicaid fee for service, uninsured, all dual (Medicare/Medicaid) eligible, and all 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, 2012 using the CMS Market Basket Index described in (A)(4) of this section. The inflated cost will be divided by total FYE June 30, 2012 acute care hospital days to determine a cost per day amount. This cost per day amount will be multiplied by the FYE June 30, 2012 acute care hospital days associated with all Medicaid fee for service, uninsured, all dual eligible, and all 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 all Medicaid fee for service, uninsured patients, all dual eligibles, and all 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 Medicaid managed care patients during FYE June 30, 2012, 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 during the October 1, 2013 - September 30, 2014 DSH Payment Period, their interim hospital specific DSH limits 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, 2013 through September 30, 2014 Medicaid State Plan rate year.

iv) For the FFY 2013/2014 DSH payment period, the Medicaid Agency created the ''Medicaid Accountability & Quality Improvement initiative''. The purpose of this initiative is to increase value and transparency in the current system, invest in hotspots of poor health, reduce per capita costs, and improve health outcomes. Through managing care for the chronically uninsured and ensuring access, the South Carolina Department of Health and Human Services (SCDHHS) will collaborate with other providers and health care organizations to improve health care value in South Carolina (SC) by improving outcomes and reducing per capita costs.

The Medicaid Disproportionate Share payment program effective October 1, 2013 will be impacted by this initiative in two ways. First, the agency will create a separate $20 million (total dollar) DSH pool from the existing FFY 2013/2014 DSH allotment that will be spread among the South Carolina defined general acute care rural hospitals as defined in Attachment 4.19-A of the SC Medicaid State Plan. This pool payment will be in addition to the SC defined general acute care rural hospital base DSH payment amount determined in accordance with the FFY 2013/2014 DSH payment methodology. In order for each South Carolina Medicaid-defined general acute care rural hospital to receive the full coverage of its uncompensated care (not to exceed $20 million in the aggregate), each SC Medicaid-defined general acute care rural hospital must participate in the Healthy Outcomes Initiative. Failure to participate in the Healthy outcomes Initiative will result in the SC defined general acute care rural hospital becoming ineligible to receive any of the $20 million DSH pool funding available. Any remaining balance of the $20 million DSH pool funding that may become available will be redistributed among the SC Medicaid defined general acute care rural hospitals that participated in the Healthy Outcomes Initiative based upon the unreimbursed DSH costs of the SC defined rural hospitals eligible to receive the payment up to its hospital specific DSH limit.

In order for the SC defined general acute care non-rural hospitals to receive one-hundred percent (100%) of its calculated DSH payment for the DSH payment period beginning October 1, 2013, each hospital will also be required to participate in the Healthy Outcomes Initiative. SC defined general acute care non-rural DSH hospitals that choose not to participate in the Healthy Outcomes Initiative will only receive ninety percent (90%) of its calculated DSH payment for the FFY 2013/2014 DSH payment period and any remaining balance (i.e.10%) that may become available will be redistributed among the SC defined general acute care non-rural DSH hospitals that participated in the Healthy Outcomes Initiative based upon the percentage of their remaining unreimbursed DSH cost to the total remaining unreimbursed DSH costs of the SC general acute care non-rural DSH hospitals eligible to receive the payment up to its hospital specific DSH limit. SCDMH hospitals are not required to participate in this initiative since they do not provide E/R services.

Finally, under this initiative, the agency will ensure that all DSH-eligible hospitals except those exempted under each requirement will participate in the Disproportionate Share Payment Accountability Initiative. Therefore, effective on the following dates the following requirements must be implemented and put into effect by

all DSH-eligible hospitals in order to continue to receive DSH payments from the SC Medicaid Program beginning with the FFY 2013/2014 DSH payment period as determined in accordance with the changes outlined below:

1. For all DSH survey responses due on or after January 1, 2014, hospitals (except DMH Hospitals) shall submit full claims data for DSH claims in response to the annual DSH survey. The data should be submitted in a commonly acceptable format, such as a comma-delimited text file or a Microsoft Excel or Access database. Beginning with the annual DSH survey for the October 1, 2013 through September 30, 2014 DSH payment period, each hospital (except SCDMH hospitals) will be required to file DSH claims data applicable to each hospitals fiscal year end 2012 cost reporting period. In addition to the standard data elements that are associated with claims data, the submission should indicate the amount of funds collected on each claim. The entire DSH payment for any hospital (except a SCDMH hospital) that does not submit such data may be denied.

2. Effective for discharges/services provided on and after April 1, 2014, hospitals (except out-of-state border hospitals and SCDMH hospitals) must provide a certification from the CEO or CFO that the hospital is following SCDHHS's recommended workflow or an SCDHHS-approved alternative workflow to ensure that Medicaid and the DSH program are the payor of last resort. SCDHHS may audit a sample of each hospital's records to determine the percentage of the hospital's uninsured patient population for which compliance with the workflow has not been documented. Based upon the results of the audit, for any hospital (except for an out-of-state border hospital or a SCDMH hospital), SCDHHS may reduce the hospital's DSH payment for up to four quarters by .5% for every 5% of the hospital's uninsured patient population for which compliance with the workflow has not been documented. However, no penalty will be assessed against the first 5% of the hospital's uninsured patient population for which compliance with the workflow has not been documented.

v. As part of the Healthy Outcomes Initiative, the SCDHHS will create three separate DSH pools for the calculation of the interim DSH payments effective October 1, 2013. 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, a $20 million DSH pool will be established from the existing FFY 2014 DSH allotment for the SC defined rural hospitals as described above. Finally, the remaining DSH allotment amount beginning October 1, 2013 will be available to all DSH eligible hospitals except for those operated by the SC Department of Mental Health (SCDMH). In the event that the sum of the hospital specific DSH limits of the SC defined rural and non-rural DSH qualifying hospitals exceeds the sum of DSH payment pool #3 beginning October 1, 2013, the hospital specific DSH limits will be decreased proportionately to ensure the hospital specific DSH limits are within the DSH payment pool #3 amount. In the event that the sum of the adjusted hospital specific DSH limits (i.e. 100% of the hospital specific DSH limit less the payment amount from DSH pool #3) of the SC defined rural hospitals exceeds payment pool #2, the adjusted hospital specific DSH limit will be

decreased proportionately to ensure that the hospital specific DSH limits are within the DSH payment pool #2 amount.

2. The October 1, 2013 - September 30, 2014 annual aggregate DSH payment amounts will not exceed the October 1, 2013 - September 30, 2014 annual DSH allotment amount.

3. Effective on or after October 1, 2013, the South Carolina Department of Health and Human Services established qualification criteria that will be used to determine those general acute care and long term acute care Disproportionate Share (DSH) hospitals that will be subject to a reduction in their federal fiscal year (FFY) 2013/2014 DSH payments. The qualification criteria will be developed using as filed hospital fiscal year (HFY) 2011 South Carolina Medicaid fee for service and uninsured individuals' total inpatient and outpatient hospital costs, South Carolina Medicaid Managed Care Organization (MCO) enrollees total inpatient and outpatient hospital costs, and the Medicare/Medicaid eligible and Medicaid/Commercial inpatient and outpatient hospital costs. These costs, which will be deemed as "DSH Eligible Costs", will be accumulated by hospital and then divided by each hospital's as filed FY 2011 total inpatient and outpatient hospital costs to determine its portion of total inpatient and outpatient hospital costs associated with providing services to low income individuals. A "DSH Eligible Costs" statewide weighted average rate will be determined by taking the sum of the "DSH Eligible Costs" and dividing it by the sum of the HFY 2011 (or 2012 data if a new DSH hospital) total inpatient and outpatient hospital costs of all general acute and long term acute care DSH qualifying hospitals which filed a HFY 2011 (or 2012 data if a new DSH hospital) cost report. All general acute care and long term acute care DSH qualifying hospitals falling under the statewide average rate will be subject to the FFY 2013/2014 DSH payment reduction except for those general acute care and long term acute care DSH hospitals that were exempted from the July 11, 2011 Medicaid inpatient and outpatient hospital payment reductions (i.e. these hospitals will be exempted from the DSH payment reduction previously described). Each impacted general acute care and long term acute care DSH hospital will receive its proportionate share of the annual DSH payment reduction amount based upon its FFY 2012/2013 interim DSH payment amounts. The total FFY 2013/2014 DSH payment reduction, on an annual basis, will amount to $8,736,559. This funding will then be redistributed to the remaining DSH eligible hospitals (excluding those operated by the SC Department of Mental Health). Upon completion of the FFY 2014 Medicaid DSH audit, the "DSH Eligible Costs" statewide average rate will be recalculated based upon audited FFY 2014 data to finalize the hospitals subject to the $8,736,559 DSH payment reduction for FFY 2014 using the methodology previously described.

4. The following CMS Market Basket index will be applied to hospitals' base year cost.

CY 2012	3.0%

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

6. Effective October 1, 2010, all interim DSH payments will become final upon audit of the applicable Medicaid State Plan Rate Year. See section IX(C)(1)(b) for additional information.

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 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 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).

The interim retrospective cost settlement amount will be determined by subtracting payments received from the allowable cost determined above. The payment amount includes Mars report payments and non Mars Report adjustments that were processed during the cost reporting/settlement period. Examples of these adjustments are small hospital access payments, interim cost settlement payments, etc. 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.

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. The redistribution methodology described below effective for the DSH payment periods beginning on and after October 1, 2011 will ensure that the final DSH payments received by each DSH hospital will not exceed its hospital specific DSH limit determined for the Medicaid State Plan Rate Year being audited.

- First, SCDHHS will create three separate DSH pools. (1) - SC state owned governmental long term psych hospitals; (2) out of state border DSH qualifying hospitals; and (3) - SC qualifying DSH Hospitals.

- Next, the SCDHHS will redistribute the interim DSH payments made to the hospitals contained within DSH pools (1) and (3) based upon the audited hospital specific DSH limits contained within the DSH audit report for the Medicaid State Plan Rate Year being audited. The final DSH payment amounts for hospitals contained within DSH pools (1) and (3) will be calculated in accordance with the methodology and pools contained within Section VII(a) (1) (a) (iv) and (v) of Attachment 4.19-A, less any DSH payments made to hospitals contained within DSH pool (2). The DSH payments for hospitals contained within DSH pool (2) will be considers settled as paid.