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State/Territory Name: South Carolina

State Plan Amendment (SPA) #:14-0019

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

March 22, 2016

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

RE: State Plan Amendment SC 14-019

Dear Mr. Soura:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid state plan submitted under transmittal number (TN) 14-019. Effective October 1, 2014 this amendment modifies the State's reimbursement methodology for setting payment rates for inpatient hospital services. Specifically, this amendment proposes to increase the hospital per discharge base rate 2.50% percent and update the swing bed and administrative day 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 October 1, 2014. 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//

Kristin Fan
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: 14-019

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, 2014

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: (@70.64%)
a. FFY 2015 $6,249,351
b. FFY 2016 $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-A, pages , 1, 2, 2a, 2b, 3, 4, 9, 10, 12, 16, 17, 22, 23, & 24

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Attachment 4.19-A, pages 1, 2, 2a, 2b, 3, 4, 9, 10, 12, 16, 17, 22, 23, & 24

10. SUBJECT OF AMENDMENT:
Inpatient Hospital Rate Update Effective October 1, 2014.

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. Soura was designated by the Governor to review and approve all State Plans

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

13. TYPED NAME:
Christian L. Soura

14. TITLE: Interim Director

15. DATE SUBMITTED: December 10, 2014

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:
12-12-14

18. DATE APPROVED: 03-22-16

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
10-01-14

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

21. TYPED NAME:
Kristin Fan

22. TITLE: Director, FMG

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

Block #8 changed to read: Attachment 4.19-A, pages 1, 2, 2a, 2b, 3, 9, 10, 16, 17, 22, 23 and 24.

Block #9 changed to read: Attachment 4.19-A, pages 1, 2, 2a, 2b, 3, 9, 10, 16, 17, 22, 23 and 24.

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, 2014:

   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. Prospective payment rates will be reimbursed to free standing short term psychiatric hospitals that contract with the SC Medicaid Program for the first time or reenter the SC Medicaid Program effective on or after July 1, 2014 via a statewide free standing short term psychiatric hospital statewide average rate (see page 17, section 2.a.)

c. 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%. Effective for discharges occurring on or after October 1, 2014, the base rate component of the July 1, 2014 per discharge rate of those hospitals impacted by the July 1, 2014 rate normalization action or the base rate component of the October 1, 2013 per discharge rate of those hospitals not impacted by the July 2014 rate normalization action 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 2.50%.

d. Effective for discharges occurring on or after October 1, 2014, all SC general acute care hospitals except those designated as SC defined rural hospitals which include all SC Critical Access Hospitals (CAH); all SC hospitals located in the state's Zip Code Tabulation Areas (ZCTAs) classified as Moderately Rural/Rural; all SC hospitals located in Primary Care Health Professional Shortage Areas (HPSAs) for Total Population; SC hospitals located in Persistent Poverty Counties with ≤130 Licensed Beds; and SC hospitals located in Equally Rural/Urban ZCTAs with ≤90 Licensed Beds plus 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 intern/resident 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, 2014, the base rate component of the July 1, 2014 per discharge rate of those hospitals impacted by the July 1, 2014 rate normalization action or the base rate component of the October 1, 2013 per discharge rate of those hospitals not impacted by the July 2014 rate normalization action of the SC general acute care hospitals other than the SC defined rural hospitals and qualifying burn intensive care unit hospitals will be increased by 2.50%.

e. Effective for discharges occurring on or after October 1, 2014, SC defined rural hospitals (see page 9) which include all SC Critical Access Hospitals (CAH); all SC hospitals located in the state's Zip Code Tabulation Areas (ZCTAs) classified as Moderately Rural/Rural; all SC hospitals located in Primary Care Health Professional

Shortage Areas (HPSAs) for Total Population; SC hospitals located in Persistent Poverty Counties with ≤130 Licensed Beds; and SC hospitals located in Equally Rural/Urban ZCTAs with ≤90 Licensed Beds which contract with the SC Medicaid Program will continue to receive retrospective cost settlements that represent one-hundred percent (100%) of allowable SC Medicaid inpatient hospital costs subject to the limitations/allowances outlined in paragraph g. below which include base, capital, DME and IME costs. Interim hospital specific per discharge rates will be established based upon a cost target set at 97%. Effective for discharges occurring on or after October 1, 2014, the base rate component of the July 1, 2014 per discharge rate of those hospitals impacted by the July 1, 2014 rate normalization action or the base rate component of the October 1, 2013 per discharge rate of those hospitals not impacted by the July 2014 rate normalization action of the SC defined rural hospitals will be increased by 2.50%.

f. Effective for discharges occurring on or after October 1, 2014, qualifying burn intensive care unit hospitals will continue to receive retrospective cost settlements that represent one-hundred percent (100%) of allowable SC Medicaid inpatient hospital costs subject to the limitations/allowances outlined in paragraph g. below which include base, capital, DME and IME costs. Interim hospital specific per discharge rates will be established based upon a cost target set at 97%. Effective for discharges occurring on or after October 1, 2014, the October 1, 2013 or July 1, 2014 base rate component of the qualifying burn intensive care unit hospitals will be increased by 2.50%.

g. Effective for discharges occurring on or after July 1, 2014, the Medicaid Agency will cap the base component of the hospital specific per discharge rates of the SC general acute care hospitals, SC short term psychiatric hospitals, and qualifying out of state border general acute care hospitals that receive a hospital specific per discharge rate at the 75th percentile of the October 1, 2013 base rate component of the SC general acute care hospitals and the SC long term acute care hospitals. The Graduate Medical Education (Direct Medical Education and Indirect Medical Education) rate components of the hospital specific per discharge rate will not be impacted by this change. For hospitals whose base component of its hospital specific per discharge rate falls below the 10th percentile of the October 1, 2013 base rate component, these hospitals will be reimbursed at the 10th percentile base rate component. However, any teaching hospital with a medical education add-on and whose base rate component falls below the 10th percentile will continue to receive their current base rate component of their October 1, 2013 hospital specific per discharge rate.

For hospitals that are eligible to receive retrospective cost reimbursement and fall under the 10th percentile, these hospitals will be eligible to receive Medicaid inpatient reimbursement in excess of cost subject to aggregate upper payment limitations. Conversely, hospitals that are eligible to receive retrospective cost reimbursement and are limited by the 75th percentile cap will be reimbursed the lower of allowable actual Medicaid reimbursable inpatient hospital costs or Medicaid inpatient hospital payments at the 75th percentile of the base rate component for discharges occurring on or after July 1, 2014.

h. 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 may submit a claim for payment only upon final discharge of the patient, with the exception of long-term care psychiatric hospital claims and psychiatric residential treatment facility claims.

3. Effective for discharges incurred on and after October 1, 2011, inpatient claim payments for all hospitals (except freestanding long-term care psychiatric hospitals) will be made based on a per discharge (per case) rate.

4. Effective for discharges incurred on or after October 1, 2011, the South Carolina Medicaid Program will reimburse inpatient hospital services based on a DRG methodology using the All Patient Refined Diagnosis Related Groups (APR-DRGs) classification system. Qualified providers of inpatient hospital services paid by APR-DRGs include: general acute care hospitals, (including distinct-part units of general hospitals), short-term psychiatric hospitals and long term acute care hospitals. Version 28 of the APR-DRG grouper and corresponding national relative weights (released in October 2010) will be used effective October 1, 2011. The same version with a mapper will be used for October 1, 2012 since there is a code freeze in effect and minimal impact is expected. The DRG grouper then will transition to the ICD-10 compliant APR-DRG version and will be updated each year to the current version.

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 that contract with the SC Medicaid Program for the first time or reenter the SC Medicaid Program effective on and after November 1, 2013 shall be based on the provider's desk reviewed cost report rate but cannot exceed the statewide average per diem rate of the governmental psychiatric long-term care providers in existence at the time the new private provider enters the Medicaid program.

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 I 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 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.

Attachment 3.1-C, page 9. Psychiatric Residential Treatment Facilities are neither acute care nor long-term care facilities. A Psychiatric Residential Treatment Facility is a facility that is accredited by the Joint Commission of Accreditation of Health Care Organizations (JCAHO), The Council on Accreditation of Services to Families and Children (COA), or The Commission on Accreditation of Rehabilitation Facilities (CARF) operated for the primary purpose of providing active treatment services for mental illness in a non-hospital based residential setting to persons under 21 years of age. Facilities must meet the federal regulations for inpatient psychiatric services at 42 CFR 440.160 and Subpart D for Part 441. Length of stay in a Psychiatric Residential Treatment Facility may range from one (1) month to more than twelve (12) months depending upon the individual's psychiatric condition as reviewed every 30 days by a physician.

35. Psychiatric Residential Treatment Facility All-Inclusive Rate - The all-inclusive rate will provide reimbursement for all treatment related to the psychiatric stay, psychiatric professional fees, and all drugs prescribed and dispensed to a client while residing in the Residential Treatment Facility.

36. Short Term Care Psychiatric Hospital - A licensed, certified hospital providing psychiatric services to patients with average lengths of stay of twenty-five (25) days or less. Patients in these hospitals will be reimbursed through the DRG payment system.

37. South Carolina Defined Rural Hospitals – Effective for inpatient and outpatient hospital services incurred/provided on or after October 1, 2014, the South Carolina Department of Health and Human Services has updated its designation of South Carolina (SC) defined rural hospitals. SC defined rural hospitals will included all SC Critical Access Hospitals (CAH); all SC hospitals located in the state's Zip Code Tabulation Areas (ZCTAs) classified as Moderately Rural/Rural; all SC hospitals located in Primary Care Health Professional Shortage Areas (HPSAs) for Total Population; SC hospitals located in Persistent Poverty Counties with ≤130 Licensed Beds; and SC hospitals located in Equally Rural/Urban ZCTAs with ≤90 Licensed Beds. ZCTAs are classed as Rural or Urban based on their population designations as defined by the 2010 Census. Each rural/urban classification reflects the relative proportion of ZCTA residents living in rural versus urban areas. These classifications are as follows:

    - Urban: 80.0% to 100.0% Urban
    - Moderately Urban: 60.0% to 79.9% Urban
    - Equally Rural/Urban: 40.1% to 59.9% Rural/Urban
    - Moderately Rural: 60.0% to 79.9% Rural
    - Rural: 80.0% to 100.0% Rural

    The percentage of the population that is not Urban is considered Rural by the US Census.

38. Special Care Unit - A unit as defined in 42 CFR 413.53 (d).

39. Standard Deviation - The square root of the sum of the squares of the deviation from the mean in a frequency distribution.

40. Teaching Hospital - A licensed certified hospital currently operating an approved intern and resident teaching program or a licensed certified hospital currently operating an approved nursing or allied health education 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, burn intensive care unit hospitals, 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 appropriate statewide average rate for that type of hospital. 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. Effective for discharges occurring on or after July 1, 2014, the Medicaid Agency will cap the base component of the hospital specific per discharge rates of the SC general acute care hospitals, SC short term psychiatric hospitals, and qualifying out of state border general acute care hospitals that receive a hospital specific per discharge rate at the 75th percentile of the October 1, 2013 base rate component of the SC general acute care hospitals and the SC long term acute care hospitals. The Graduate Medical Education (Direct Medical Education and Indirect Medical Education) rate components of the hospital specific per discharge rate will not be impacted by this change. For hospitals whose base component of its hospital specific per discharge rate falls below the 10th percentile of the October 1, 2013 base rate component, these hospitals will be reimbursed at the 10th percentile base rate component. However, any teaching hospital with a medical education add-on and whose base rate component falls below the 10th percentile will continue to receive their current base rate component of their October 1, 2013 hospital specific per discharge rate.

g. Effective for discharges incurred on or after October 1, 2014, the July 1, 2014 or October 1, 2013 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 in the base year (HFY 2011) and all SC general acute care hospitals which include both the SC defined rural, qualifying burn intensive care unit hospitals, as well as the SC non-rural general acute care hospitals will be increased by 2.50%.

h. For all other hospitals that did not receive a hospital specific per discharge rate, a statewide per discharge rate was developed for general acute care hospitals and long term acute care hospitals (LTAC) 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. For free standing short term psych hospitals that are new or are reentering the SC Medicaid Program effective on or after October 1, 2013, the statewide average rate will represent the weighted average rate of free standing short term psych hospitals that are eligible to receive a November 1, 2012 hospital specific rate weighted by hospital fiscal year 2011 total discharges.

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

2. A. 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 applicable CMS Market Basket Rates for Inpatient Psychiatric Facilities to determine the trend rate of 5.37%:

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 for private long term psychiatric hospitals effective November 1, 2013. The hospital will be reimbursed based upon the lesser of its calculated per diem based upon actual costs or the statewide rate.

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 - September 30, 2014	162.19
October 1, 2014 -	167.68

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 Pharmacy per diem used for nursing facility UPL payments:

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 September 30, 2014	171.08 (ARM 8.89)
October 1, 2014 -	180.76 (Pharmacy Per Diem 13.08)

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, 2014, 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, 2014, SC general acute care hospitals which are designated as SC defined rural hospitals 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, subject to the exceptions provided in the July 1, 2014 inpatient hospital normalization action.

- 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, subject to the exceptions provided in the July 1, 2014 inpatient hospital normalization action.

- Effective for discharges occurring on or after July 1, 2014, hospitals that are eligible to receive retrospective cost reimbursement and fall under the 10th percentile will be eligible to receive the greater of Medicaid inpatient reimbursement or allowable Medicaid reimbursement cost subject to aggregate upper payment limitations. Conversely, hospitals that are eligible to receive retrospective cost reimbursement and are limited by the 75th percentile cap will be reimbursed the lower of allowable actual Medicaid reimbursable inpatient hospital costs or Medicaid inpatient hospital payments at the 75th percentile of the base rate component for discharges occurring on or after July 1, 2014.

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 2013 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 for federal fiscal year 2013 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 First Quarter 2014 Global Insight Indexes of 2010 Based CMS Hospital PPS Market Basket in order to trend the base year cost (HFY 2013) to the Medicaid rate period October 1, 2014 through September 30, 2015.

(6) Total Medicaid inpatient hospital revenue is derived from each hospital's Summary MARS report.

(7) Next, to account for the changes in Medicaid payment/rate updates since the base year, the Medicaid Agency applied the percentage increase change in the October 1, 2013 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 July 1, 2014,and October 1, 2014, the annual estimated Medicaid revenue in step (7) was multiplied by the hospital specific increases/(decreases) associated with the actions listed above to determine the projected Medicaid revenue for the period October 1, 2014 through September 30, 2015. For hospitals that continue to receive retrospective cost settlements at 100% of allowable costs on and after October 1, 2014, the estimated revenue for the October 1, 2014 through September 30, 2015 payment period equals the trended inflated cost as described in step (5) subject to the impact of the July 1, 2014 rate normalization action.

(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 (8). 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 (5) 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 2013 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 First Quarter 2014 Global Insight Indexes of 2010 Based CMS Hospital PPS Market Basket in order to trend the base year cost (HFY 2013) to the Medicaid rate period October 1, 2014 through September 30, 2015.

(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 November 1, 2013 Medicaid per diem rate multiplied by the HFY 2013 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.

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 2013 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, 2013, 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, 2013. 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.

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 2013 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, 2013, 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, 2013. 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.