# Table of Contents

**State/Territory Name: South Carolina**

**State Plan Amendment (SPA) #:15-0011**

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 15-011

Dear Mr. Soura:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid state plan submitted under transmittal number (TN) 15-011. Effective October 1, 2015 this amendment modifies the State's reimbursement methodology for setting payment rates for inpatient hospital services. Specifically, this amendment will cap the hospital per discharge base rate at the 65 percentile of the October 1, 2014 base rate, increase hospital base rates that fall below the 15$^{th}$ percentile up to the 15$^{th}$ percentile, and for hospitals eligible for retrospective cost settlement cap the payments to the lower of actual allowable cost or the 65$^{th}$ percentile.

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, 2015. 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: SC 15-011

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, 2015

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 Part 447 Subpart C

7. FEDERAL BUDGET IMPACT:
a. FFY 2016 $ (1,453,717)
b. FFY 2017 $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-A pages, 1, 2a, 2b, 3, 10, 11, 14, 15, 16, 17, 19, 20, 22, 23, 24, 26a, 26a.1, 26a.2, 26c, 26d, 26f, 26g, 29, & 33

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Attachment 4.19-A pages, 1, 2a, 2b, 3, 10, 11, 14, 15, 16, 17, 19, 20, 22, 23, 24, 26a, 26a.1, 26a.2, 26c, 26d, 26f, 26g, 29, & 33

10. SUBJECT OF AMENDMENT:
Normalization adjustment to October 1, 2014 SC Medicaid per discharge rates and repricing of rates effective October 1, 2015 based upon Version 32 of the APR-DRG grouper and associated relative weights.

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:
Director

15. DATE SUBMITTED:
December 29, 2015

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: 12/30/15

18. DATE APPROVED: 03/22/16

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
10/01/15

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

21. TYPED NAME: Kristin Fan

22. TITLE: Director, FMG

23. REMARKS:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF SOUTH CAROLINA

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

I. General Provisions

A. Purpose

This plan establishes:

1. a retrospective reimbursement system for qualifying 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, 2015:

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 16, section 1.e.).

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. and h. 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 75$^{th}$ 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 10$^{th}$ percentile of the October 1, 2013 base rate component, these hospitals will be reimbursed at the 10$^{th}$ percentile base rate component. However, any teaching hospital with a medical education add-on and whose base rate component falls below the 10$^{th}$ 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 10$^{th}$ 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 75$^{th}$ percentile cap will be reimbursed the lower of allowable actual Medicaid reimbursable inpatient hospital costs or Medicaid inpatient hospital payments at the 75$^{th}$ percentile of the base rate component for discharges occurring on or after July 1, 2014.

h. Effective for discharges incurred on and after October 1, 2015, 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 65th percentile of the October 1, 2014 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 15th percentile of the October 1, 2014 base rate component, these hospitals will be reimbursed at the 15th percentile base rate component. However, any teaching hospital with a medical education add-on and whose base rate component falls below the 15th percentile will continue to receive their current base rate component of their October 1, 2014 hospital specific per discharge rate.

For hospitals that are eligible to receive retrospective cost reimbursement and fall under the 15th 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 65th percentile cap will be reimbursed the lower of allowable actual Medicaid reimbursable inpatient hospital costs or Medicaid inpatient hospital payments at 65th percentile of the base rate component for discharges incurred on and after October 1, 2015.

i. 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. Effective for discharges incurred on and after October 1, 2015, the Medicaid Agency will reimburse inpatient hospital services using version 32 of 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 acute care hospitals), short term psychiatric hospitals, and long term acute care hospitals. Version 32 of the APR-DRG grouper and corresponding national relative weight will be used effective October 1, 2015.

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

7. 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.

8. 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.

9. 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.

10. 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.

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

12. 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.

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

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, 2015 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, 2012 through June 30, 2013 incurred inpatient hospital claims, October 1, 2014 inpatient hospital rates adjusted by the October 1, 2015 normalization adjustment, hospital specific add-ons, case mix index, and an upcode adjustment factor.

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 October 1, 2015, the Medicaid Agency will determine inpatient hospital claim payments based upon the DRG listing contained within version 32 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.

B. Allowable Inpatient Costs

For acute care, freestanding short term psychiatric, and long term acute care hospital inpatient rates effective on and after November 1, 2012, allowable inpatient cost information of covered services from each hospital's FY 2011 cost report (adjusted for the impact of the HFY 2010 audit adjustment factor) will serve as the basis for computation of the hospital specific per discharge rate and the statewide average per discharge rate. All free standing short term psychiatric, long term acute care and contracting SC acute care hospitals as well as out of state contracting border hospitals with SC Medicaid inpatient claim utilization of at least 10 claims and a S. C. Medicaid cost report were used in this analysis. The source document for Medicaid allowable inpatient costs will be the CMS-2552, which is the Medicare/Medicaid cost report. Allowable Medicaid inpatient costs will be determined in accordance with the Provider Reimbursement Manual Publication 15. However, no adjustment will be made to carve out the private room differential costs. For clarification purposes one hundred percent of the South Carolina general acute care hospital provider tax will be considered an allowable Medicaid cost. Medicare's recent policy change relating to the inclusion of Medicaid labor and delivery patient days in the Medicare Disproportionate Share calculation effective for cost reporting periods beginning on and after October 1, 2009 will have no impact on the calculation of allowable Medicaid inpatient hospital costs beginning on and after October 1, 2009. Hospitals will continue to determine patient days for maternity patients in accordance with the provisions of the Provider Reimbursement Manual HIM-15, section 2205.2. Inpatient allowable costs, charges and statistics will be extracted from the cost report and prepared for the rate computations using the following general guidelines. The FY 2011 SCDHHS MARS paid claims summary data report for each acute care hospital identified above will also be used during the analysis.

1. As filed total facility costs are identified from each facility's FY 2011 Worksheet B Part I (BI) CMS-2552 cost report. Total inpatient facility costs would include operating, capital, direct medical education, and indirect medical education costs. Swing bed and Administrative Day payments are deducted from the adult and pediatric cost center on the CMS-2552 as well as CRNA costs. Observation cost is reclassified.

2. As filed total facility costs will be allocated to Medicaid inpatient hospital cost using the following methods.

   a. A cost-to-charge ratio for each ancillary service will be computed by dividing total costs as adjusted in this section by total charges as reported on Worksheet C. This cost-to-charge ratio will then be multiplied by SC Medicaid covered charges as (as reported on Worksheet D-3 for Medicaid inpatient ancillary charges) to yield total SC Medicaid inpatient ancillary costs.

   b. SC Medicaid routine service costs will be computed by dividing each routine cost center by total patient days of the applicable routine cost center and then multiplying by the applicable SC Medicaid covered patient days. Total SC Medicaid routine costs will represent the accumulation of the SC Medicaid cost determined from each applicable routine cost center.

D. DRG Relative Weights

The relative weights used for calculating reimbursement for hospitals paid under the DRG payment system will be the corresponding national relative weights of version 32 of the APR-DRG grouper. Relative weights will be reviewed annually and updated as needed at the same time as the DRG grouper is updated.

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, 2012 through June 30, 2013 by the DRG relative weight, summing these amounts and dividing by the sum of the total per case discharges. Version 32 of the APR-DRG grouper and the corresponding national relative weights 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 October 1, 2015:

The following methodology is employed in the computation of the hospital specific per discharge rates effective October 1, 2015:

a. First, the October 1, 2014 hospital specific per discharge rates under version 28 of the APR-DRG grouper were adjusted to account for the October 1, 2015 inpatient hospital normalization adjustment. Effective for discharges incurred on and after October 1, 2015, 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 65$^{th}$ percentile of the October 1, 2014 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 15$^{th}$ percentile of the October 1, 2014 base rate component, these hospitals will be reimbursed at the 15$^{th}$ percentile base rate component. However, any teaching hospital with a medical education add-on and whose base rate component falls below the 15$^{th}$ percentile will continue to receive their current base rate component of their October 1, 2014 hospital specific per discharge rate.

b. Next, the Medicaid Agency established individual hospital specific baseline expenditure targets for each hospital eligible to receive a hospital specific per discharge rate by pricing each hospital's incurred inpatient hospital claims for the July 1, 2012 through June 30, 2013 period against its October 1, 2015 inpatient hospital per discharge rate described in a. above.

c. Next, as a starting point, an initial estimated hospital specific per discharge rate was established for each hospital and was used to reprice each hospital's incurred inpatient hospital claims for the period July 1, 2012 through June 30, 2013 using the payment criteria reflected below. The total claims payment amount for each hospital was then compared to each hospital's specific baseline expenditure target to determine whether to increase or decrease the initial estimated hospital specific per discharge rate. Model simulations were run for each hospital until each hospital's total claims payment amount, using the final hospital specific per discharge rate and the incurred inpatient hospital claims for the period July 1, 2012 through June 30, 2013, equaled each hospital's specific baseline expenditure target.

    1. DRGs as defined by version 32 of the APR-DRG grouper as well as the corresponding national relative weights;

    2. Hospital specific case mix index as determined from the use of the grouper and relative weights as described in 1.a.above;

    3. The effect of the updated cost outlier thresholds as outlined in Section VI (A) of the plan;

    4. Transfers and same day and one day stays reimbursed in accordance with Section VI (B and C) of the plan;

    5. An upcode adjustment factor of two percent (2%) was built within the October 1, 2015 per discharge rates under version 32 of the APR-DRG grouper.

d. Next, once each teaching hospital's specific per discharge rate was determined in accordance with step c above, the Direct Medical Education and Indirect Medical education components for each hospital was developed by taking the calculated hospital specific per discharge rate in step c and breaking the rate down into three components (i.e. base, DME, and IME) based upon the component percentages of the baseline hospital specific rates effective October 1, 2015 under version 28 of the APR-DRG grouper described in (a) above.

e. For all other hospitals that did not receive a hospital specific per discharge rate, a statewide per discharge rate was first developed by 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 October 1, 2015 rate setting (i.e. July 1, 2012 through June 30, 2013 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 October 1, 2015.

f. The rates described in d and e above are then multiplied by the relative weight for that DRG to calculate the reimbursement for each DRG claim.

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.

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, 2012 through June 30, 2013 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.

- For DRGs with between 24 and 5 stays, set the initial cost outlier threshold at the average cost times 2.30.

- For DRGs with fewer than 5 South Carolina stays but some stays in the national dataset, estimate the average cost of these DRGs at average national charges times 30%, which is a reasonable cost to charge ratio based upon South Carolina data. For these DRGs, set the initial cost outlier threshold at estimated average cost times 2.30.

- For DRGs with no stays in the national dataset, set the initial cost outlier threshold as the estimated average cost of a closely related DRG times 2.30.

- If the initial threshold is below $33,000, set it at $33,000. If the initial threshold is above $98,000, set it at $98,000. If the initial threshold is between $33,000 and $98,000, leave it as is.

2. Additional payments for cases meeting the conditions in 1a above (cost outliers) will be made as follows:

   a. If the hospital discharge includes cost beyond the sum of the threshold and the DRG payment for the applicable DRG, an additional payment will be made to the provider for those costs. A special request by the hospital is <u>not</u> required in order to initiate this payment.

   b. Charges for any services identified through utilization review as non-covered services, will be denied and any outlier payment made for these services will be recovered.

   c. The additional payment amount for cost outlier shall be derived by multiplying 60% of the difference between the hospital's adjusted cost for the discharge less the threshold described in 1 b of this section less the DRG payment amount. The hospital's total payment for the case will be the DRG rate specified in Section V plus the outlier payment as described in this section.

B. <u>Payment for Transfers</u>

1. Special payment provisions will apply when a patient has been transferred from one hospital to another.

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.

| | |
|---|---|
| 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 - September 30, 2015 | 167.68 |
| October 1, 2015 - | 168.65 |

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:

| | |
|---|---|
| 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 - September 30, 2015 | 180.76 (Pharmacy Per Diem 13.08) |
| October 1, 2015 - | 183.85 (RX Per Diem 15.20) |

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.

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 10$^{th}$ 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 75$^{th}$ percentile cap will be reimbursed the lower of allowable actual Medicaid reimbursable inpatient hospital costs or Medicaid inpatient hospital payments at the 75$^{th}$ percentile of the base rate component for discharges occurring on or after July 1, 2014.

- Effective for discharges incurred on and after October 1, 2015, hospitals that are eligible to receive retrospective cost reimbursement and fall under the 15$^{th}$ percentile will be eligible to receive the greater of Medicaid inpatient reimbursement in excess of cost or allowable Medicaid reimbursable cost subject to aggregate upper payment limitations. Conversely, hospitals that are eligible to receive retrospective cost reimbursements and are limited by the 65$^{th}$ percentile cap will be reimbursed the lower of allowable actual Medicaid reimbursable inpatient hospital costs or Medicaid inpatient hospital payments at the 65$^{th}$ percentile of the base rate component for discharges incurred on and after October 1, 2015.

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 2014 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 2014 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 Second Quarter 2015 Global Insight Indexes of 2010 Based CMS Hospital PPS Market Basket in order to trend the base year cost (HFY 2014) to the Medicaid rate period October 1, 2015 through September 30, 2016.

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

(7) Next, to account for the changes in the Medicaid payment/rate updates effective July 1, 2014, October 1, 2014, and the impact of the October 1, 2015 normalization action on the October 1, 2014 per discharge rates, the annual Medicaid revenue in step (6) was multiplied by the hospital specific increases/(decreases) associated with the actions listed above (75% of the July 1, 2014 increase/(decrease) and 100% of the October 1, 2014 and October 1, 2015 increase/(decrease)) to determine the projected Medicaid revenue for the period October 1, 2015 through September 30, 2016. 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, 2015 through September 30, 2016 payment period equals the trended inflated cost as described in step (5) subject to the impact of the July 1, 2014 and October 1, 2015 rate normalization actions.

(8) The Medicaid UPL compliance check is determined for each class by comparing the aggregate amounts as determined in (5) above to ensure that projected Medicaid inpatient hospital cost is equal to or greater than projected Medicaid inpatient hospital rate expenditures in step (7). In the event that aggregate Medicaid inpatient hospital rate expenditures exceed aggregate Medicaid hospital cost, the Medicaid per discharge rate for each facility will be limited to the Medicaid cost based rate as determined in (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 2014 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 Second Quarter 2015 Global Insight Indexes of 2010 Based CMS Hospital PPS Market Basket in order to trend the base year cost (HFY 2014) to the Medicaid rate period October 1, 2015 through September 30, 2016.

(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 2014 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 2014 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, 2014, base year cost will be trended accordingly using CMS Market Basket rates. For payments made on and after October 1, 2014, 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 (2nd Qtr. 2015 Edition). Medicaid base year revenue will be adjusted accordingly (75% of the July 1, 2014 increase/(decrease) and 100% of the October 1, 2014 and October 1, 2015 increase/(decrease)) to reflect changes made to SC Medicaid inpatient hospital reimbursement since October 1, 2014. 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 2014 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, 2014, base year cost will be trended accordingly using CMS Market Basket rates. For payments made on and after October 1, 2014, 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 (2nd Qtr. 2015 Edition). Medicaid base year revenue will be adjusted accordingly (75% of the July 1, 2014 increase/(decrease) and 100% of the October 1, 2014 and October 1, 2015 increase/(decrease)) to reflect changes made to SC Medicaid inpatient hospital reimbursement since October 1, 2014. 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.

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. The payment amount does not include payments authorized in Sections VI (N) or IV (O) of the State Plan. 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.

Effective for discharges occurring on or after July 1, 2014, hospitals that are eligible to receive retrospective cost reimbursement and fall under the 10$^{th}$ percentile 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 75$^{th}$ percentile cap will be reimbursed the lower of allowable actual Medicaid reimbursable inpatient hospital costs or Medicaid inpatient hospital payments at the 75$^{th}$ percentile of the base rate component for discharges occurring on or after July 1, 2014.

Effective for discharges incurred on and after October 1, 2015, hospitals that are eligible to receive retrospective cost reimbursement and fall under the 15$^{th}$ percentile will be eligible to receive the greater of Medicaid inpatient reimbursement in excess of cost or allowable Medicaid reimbursable cost subject to aggregate upper payment limitations. Conversely, hospitals that are eligible to receive retrospective cost reimbursement and are limited by the 65$^{th}$ percentile cap will be reimbursed the lower of allowable actual Medicaid reimbursable inpatient hospital costs or Medicaid inpatient hospital payments at the 65$^{th}$ percentile of the base rate component for discharges incurred on and after October 1, 2015.

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 and adjusted to reflect the impact of the July 1, 2014 and October 1, 2015 SC Medicaid fee for service inpatient and outpatient hospital rate/multiplier normalization action 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) ,(v), and (vi) 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 considered settled as paid.