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State/Territory Name: South Carolina18-0014

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form
3) Approved SPA Pages

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

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Financial Management Group

July 23, 2019

Joshua D. Baker, Director
Department of Health & Human Services
1801 Main Street
Columbia, SC 29201

RE: State Plan Amendment (SPA) 18-0014

Dear Mr. Baker:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number 18-0014. Effective January 1, 2019 this amendment proposes to update the DSH program including: (1) updates the base year used to calculate the interim DSH payments and update the inflation rate used to trend the DSH base year cost; and (2) expend 100% of its FFY 2019 allotment; (3) continue to apply a normalization adjustment to the hospital specific DSH limits; and (4) amend the redistribution policy so that DSH overpayments will be recovered and then redistributed to those eligible DSH hospitals whose interim DSH payment did not exceed their DSH limits.

Also effective January 1, 2019 SC will update the swing bed and administrative day rates based on the updated October 1, 2018 NF rates.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a), and 1923 of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C. We have found that the proposed reimbursement methodology complies with applicable requirements and therefore have approved them with an effective date of October 1, 2018. We are enclosing the CMS-179 and the amended approved plan pages.

If you have any questions, please call Anna Dubois at (850) 878-0916.

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: 18-0014

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
January 1, 2019

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: ($15 million x .7122)
a. FFY 2019 $ 10.7 million
b. FFY 2020 $ 10.7 million

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-A pages, 22, 26a, 26a.1, 26a.2, 26c, 26d, 26f, 26g, 27, 28, 28a, 28a.1, 33 & 33a

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Attachment 4.19-A pages, 22, 26a, 26a.1, 26a.2, 26c, 26d, 26f, 26g, 27, 28, 28a, 28a.1, 33 & 33a

10. SUBJECT OF AMENDMENT:
FFY 2019 DSH Payment Methodology Updates and Swing Bed and Administrative Day Rate Updates Effective January 1, 2019.

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

12. SIGNATURE OF STATE AGENCY OFFICIAL:
/s/

13. TYPED NAME:
Joshua D. Baker

14. TITLE:
Director

15. DATE SUBMITTED:
December 31, 2018

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:
12/31/18

18. DATE APPROVED: 07/23/19

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
07/01/19

20. SIGNATURE OF REGIONAL OFFICIAL:
/s/

21. TYPED NAME: Kristin Fan

22. TITLE: Director, FMG

23. REMARKS:

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, 2013 - September 30, 2014	162.19
October 1, 2014 - September 30, 2015	167.68
October 1, 2015 - September 30, 2016	168.65
October 1, 2016 - September 30, 2017	171.04
October 1, 2017 - December 31, 2018	176.70
January 1, 2019 -	181.87

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, 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 - September 30, 2016	183.85 (RX Per Diem 15.20)
October 1, 2016 - September 30, 2017	187.97 (RX Per Diem 16.93)
October 1, 2017 - December 31, 2018	195.27 (RX Per Diem 18.57)
January 1, 2019 -	202.21 (RX Per Diem 20.34)

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.

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 2017 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 2017 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 2018 Global Insight Indexes of 2014 Based CMS Hospital PPS Market Basket in order to trend the base year cost (HFY 2017) to the Medicaid rate period October 1, 2018 through September 30, 2019.

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

(7) Next, For hospitals that continue to receive retrospective cost settlements at 100%, 90%, or 80% of allowable costs on and after October 1, 2018, the estimated revenue for the October 1, 2018 through September 30, 2019 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 2017 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 2018 Global Insight Indexes of 2014 Based CMS Hospital PPS Market Basket in order to trend the base year cost (HFY 2017) to the Medicaid rate period October 1, 2018 through September 30, 2019.

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

(5) Total projected Medicaid inpatient hospital revenue is determined by taking the October 1, 2018 Medicaid per diem rate multiplied by the HFY 2017 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 2017 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, 2018, base year cost will be trended accordingly using CMS Market Basket rates. For payments made on and after October 1, 2018, base year cost will be trended using the midpoint to midpoint methodology and the use of the Global Insight 2014 Based CMS Hospital Prospective Reimbursement Quarterly Market Basket Indexes (1st Qtr. 2018 Edition). Medicaid base year revenue will be adjusted accordingly, if applicable, to reflect changes made to SC Medicaid inpatient hospital reimbursement due to the October 1, 2014 rate update and the October 1, 2015 rate/normalization action. 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 2017 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, 2018, base year cost will be trended accordingly using CMS Market Basket rates. For payments made on and after October 1, 2018, base year cost will be trended using the midpoint to midpoint methodology and the use of the Global Insight 2014 Based CMS Hospital Prospective Reimbursement Quarterly Market Basket Indexes (1st Qtr. 2018 Edition). Medicaid base year revenue will be adjusted accordingly, if applicable, to reflect changes made to SC Medicaid inpatient hospital reimbursement due to the October 1, 2014 rate update and the October 1, 2015 rate/normalization action. 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.

VII. Disproportionate Share

A. Payments

Disproportionate share hospital (DSH) payments shall be made in accordance with the requirements of Section 1923 of the Social Security Act. DSH payments will be paid to those facilities meeting the requirements specified in Section II 12. For clarification purposes, the South Carolina Medicaid State Plan rate year for DSH payment purposes is October 1 through September 30. For FFY 2019, qualification data will be based upon each hospital's fiscal year 2017 cost reporting period.

1. Effective for the October 1, 2018 - September 30, 2019 DSH payment period, the interim hospital specific DSH limit will be set as follows:

a. The interim hospital specific DSH limit for most SC general acute care hospitals that contract with the SC Medicaid Program will be equal to one hundred percent (100%) of the unreimbursed hospital cost for all (i.e. SC and out-of-state) uninsured patients, all Medicaid fee for service patients, all Medicaid managed care patients (including PACE Program participants), SC dual (Medicare/Medicaid) eligible patients, and all Medicaid patients who have inpatient and outpatient hospital services reimbursed by a commercial carrier. The hospital specific DSH limit for the SC general acute care hospitals that became rural for the first time under the SC defined Rural Hospital criteria will be equal to 90% for a hospital deemed rural for the first time effective October 1, 2014 and 80% for a hospital deemed rural for the first time effective October 1, 2016. The hospital specific DSH limit of the SC non-general acute care hospitals will equal to sixty percent (60%). The hospital specific DSH limit for all general acute care border hospitals (in North Carolina and Georgia) contracting with the SC Medicaid Program will be equal to sixty percent (60%) of the unreimbursed hospital cost for SC uninsured patients, SC Medicaid fee for service patients, SC Medicaid managed care patients (including PACE Program participants), SC dual (Medicare/Medicaid) eligible patients, and SC Medicaid patients who have inpatient and outpatient hospital services reimbursed by a commercial carrier. The December 19, 2008 Final Rule (as well as instructions/guidance provided by the DSH audit contractor) relating to the audits of the Medicaid DSH plans as well as the December 3, 2014 Final Rule relating to the Uninsured Definition will be the guiding documents that hospitals must use in providing the DSH data. When calculating the hospital specific DSH limit for both the SC general acute care hospitals as well as the out of state border hospitals and the SC non-general acute care hospitals which qualify for the SC Medicaid DSH Program effective for the FFY 2019 DSH payment period, the Medicaid Agency will adjust the limit of the impacted hospitals for the impacts relating to the July 1, 2014 and October 1, 2015 Medicaid fee for service inpatient hospital per discharge rate and outpatient hospital multiplier normalization action.

Except for the SC Department of Mental Health (SCDMH) hospitals, for FFY 2019, each hospital's interim hospital specific DSH limit will be calculated as follows:

i) The unreimbursed cost of providing inpatient and outpatient hospital services to the uninsured, Medicaid fee for service, Medicaid MCO enrollees, dual eligibles, and Medicaid eligibles who have inpatient and outpatient hospital services reimbursed by a commercial carrier will be determined by taking each hospital's fiscal year 2017 cost reporting period charges for

each group listed above and multiplying that by the hospital's applicable FY 2017 unadjusted inpatient and outpatient hospital cost to charge ratios (i.e. Uninsured, Medicaid MCO, Medicaid FFS, and Medicare (Dual Eligibles)) to determine the base year cost for this group. In order to inflate each hospital's base year cost determined for each group identified above, each hospital's cost will be inflated from the base year to December 31, 2017 using the applicable CMS Market Basket Index described in (A)(3) of this section. The inflated cost of each hospital for each group determined above will be summed and reduced by payments received from or for all uninsured patients, all Medicaid fee for service, all dual eligibles, all Medicaid eligibles who have inpatient and outpatient hospital services reimbursed by a commercial carrier, and all Medicaid managed care patients to determine the total unreimbursed cost for each DSH hospital. HFY 2017 base revenue for Medicaid fee for service and Medicaid managed care enrollees will be adjusted to account for any Medicaid fee for service reimbursement actions implemented during or after the base year. Out of state border DSH qualifying hospitals will only report charges and revenue received from SC residents. Additionally, to adjust for the hospital specific rate and outpatient multiplier normalization actions effective July 1 2014 and October 1, 2015 that impacted certain hospitals, the Medicaid Agency will adjust the following DSH eligible unreimbursed cost pools as follows:

- Medicaid FFS unreimbursed cost pool - for hospitals that received a reduction in their Medicaid FFS hospital specific per discharge rate or outpatient multiplier effective July 1, 2014 and/or October 1, 2015, total Medicaid FFS inpatient or outpatient cost will be reduced by the July 1, 2014 and October 1, 2015 percentage rate/multiplier changes. However please note that in order to account for the utilization of services that occur in the outpatient hospital setting (i.e. the use of outpatient hospital clinic services and emergency room services (available only if provided in a SC Level I Trauma Center hospital) versus all other ancillary services provided in an outpatient hospital setting), the Medicaid Agency will adjust the outpatient hospital normalization percentage adjustment downward based upon the ratio of SC Medicaid fee for service outpatient hospital clinic costs (and ER costs if applicable) to total SC Medicaid fee for service outpatient hospital ancillary service costs of those impacted hospitals.

- Medicaid MCO unreimbursed cost pool - for hospitals that received a reduction in their Medicaid FFS hospital specific per discharge rate or outpatient multiplier effective July 1, 2014 and/or October 1, 2015, total Medicaid MCO inpatient or outpatient cost will be reduced by the July 1, 2014 and October 1, 2015 percentage rate/multiplier changes. However please note that in order to account for the utilization of services that occur in the outpatient hospital setting (i.e. the use of outpatient hospital clinic services and emergency room services (available only if provided in a SC Level I Trauma Center hospital) versus all other ancillary services provided in an outpatient hospital setting), the Medicaid Agency will adjust the outpatient hospital normalization percentage adjustment downward based upon the ratio of SC Medicaid fee for service outpatient hospital clinic costs (and ER costs if applicable) to total SC Medicaid fee for service outpatient hospital ancillary service costs of those impacted hospitals.

- Uninsured unreimbursed cost pool - for hospitals that received a reduction in their Medicaid FFS hospital specific per discharge rate or outpatient multiplier effective July 1, 2014 and/or October 1, 2015, total Uninsured inpatient or outpatient cost will be reduced by the July 1, 2014 and October 1, 2015 percentage rate/multiplier changes.

However please note that in order to account for the utilization of services that occur in the outpatient hospital setting (i.e. the use of outpatient hospital clinic services and emergency room services (available only if provided in a SC Level I Trauma Center hospital) versus all other ancillary services provided in an outpatient hospital setting), the Medicaid Agency will adjust the outpatient hospital normalization percentage adjustment downward based upon the ratio of SC Medicaid fee for service outpatient hospital clinic costs (and ER costs if applicable) to total SC Medicaid fee for service outpatient hospital ancillary service costs (including clinics) of those impacted hospitals.

ii) For FFY 2019, each SCDMH hospital's interim hospital specific DSH limit will be calculated using FYE June 30, 2017 cost report data for all of its Medicaid fee for service, uninsured, all dual (Medicare/Medicaid) eligible, and all Medicaid eligibles who have inpatient hospital services reimbursed by a commercial carrier. Each hospital's total allowable cost will be inflated from the base year to December 31, 2017 using the CMS Market Basket Index described in (A)(3) of this section. The inflated cost will be divided by total FYE June 30, 2017 acute care hospital days to determine a cost per day amount. This cost per day amount will be multiplied by the FYE June 30, 2017 acute care hospital days associated with all Medicaid fee for service, uninsured, all dual eligible, and all Medicaid eligibles who have inpatient hospital services reimbursed by a commercial carrier to determine the total amount of cost eligible under the hospital specific DSH limit. The inflated cost of each hospital determined above will be reduced by payments received from or for all Medicaid fee for service, uninsured patients, all dual eligibles, and all Medicaid eligibles who have inpatient and outpatient hospital services reimbursed by a commercial carrier to determine the total unreimbursed cost of each DSH hospital. Medicaid fee for service revenue will be adjusted to account for any Medicaid rate increase provided since the base year. In the event that any of the SCDMH hospitals provided inpatient hospital services for Medicaid managed care patients during FYE June 30, 2017, the previous methodology outlined above will be used to determine the unreimbursed Medicaid managed care cost to be added to the unreimbursed Medicaid eligible and uninsured cost previously described.

iii) For new S. C. general acute care hospitals which enter the SC Medicaid Program during the October 1, 2018 - September 30, 2019 DSH Payment Period, their interim hospital specific DSH limits will be based upon projected DSH qualification, cost, charge and payment data that could be subject to further revision based upon the audited DSH qualification, cost, charge and payment data resulting from the audit of the October 1, 2018 through September 30, 2019 Medicaid State Plan rate year.

iv) For the FFY 2018/2019 DSH payment period, proviso 33.20 (C) of the July 1, 2018 through June 30, 2019 South Carolina State Appropriations Act provides that SC Medicaid-designated rural hospitals in South Carolina shall be eligible to receive up to one hundred percent of costs associated with uncompensated care as part of the DSH program. Funds shall be allocated from the existing DSH program. To be eligible, rural hospitals must participate in reporting and quality guidelines published by the department and outlined in the Healthy Outcomes Initiative. Therefore based upon this proviso language, the Medicaid Agency will reimburse the following SC defined rural hospitals at the following percentages of their hospital specific DSH limit for FFY 2019:

- Hospitals designated as SC defined rural hospitals prior to October 1, 2014 will receive 100% of their hospital specific DSH limit (Abbeville, Allendale, CHS - Marion, Chester, McLeod Cheraw, Clarendon, Coastal, Colleton, Edgefield, Fairfield, GHS Laurens, Hampton, Lake City, McLeod Dillon, Newberry, and Williamsburg);

- Hospitals designated as a SC Defined rural hospital for the first time on and after October 1, 2014 will receive 90% of their hospital specific DSH limit (Cannon, McLeod Loris, and Union);

- Hospitals designated as a SC defined rural hospital for the first time on and after October 1, 2016 will receive 80% of their hospital specific DSH limit (The Regional Medical Center).

v. Effective for the FFY 2019 DSH payment period, the SCDHHS will create three separate DSH pools for the calculation of the interim DSH payments effective October 1, 2018. The first DSH pool will represent the unreimbursed costs of the uninsured and Medicaid eligible recipients receiving inpatient psychiatric hospital services provided by South Carolina Department of Mental Health (SCDMH) hospitals. Under this pool, the SCDMH hospitals will receive (in the aggregate) up to one hundred percent of their specific DSH limit but not to exceed $60,903,051. Next, a second DSH pool will be created for SC defined rural hospitals from the existing FFY 2019 DSH allotment for the SC defined rural hospitals as described in iv. above. Finally, the remaining DSH allotment amount beginning October 1, 2018 will be available to all remaining DSH eligible hospitals. In the event that the sum of the hospital specific DSH limits of the DSH qualifying hospitals exceeds the sum of DSH payment pool #3 beginning October 1, 2018, the hospital specific DSH limits will be decreased proportionately to ensure the hospital specific DSH limits are within the DSH payment pool #3 amount.

2. The October 1, 2018 - September 30, 2019 annual aggregate DSH payment amounts will not exceed the October 1, 2018 - September 30, 2019 annual DSH allotment amount.

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

FY 2017 2.7%

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

5. Effective October 1, 2018, the Medicaid Agency will employ the use of the DSH audit redistribution methodology as outlined under Section IX(C)(1)(b)of Attachment 4.19-A.

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, 2018 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.

1. First, SCDHHS will identify and group the DSH qualifying hospitals into 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.

2. Next, hospitals within DSH pools (1) and (3) will be separately reviewed within each pool to identify those hospitals whose audited hospital specific DSH limits are less than their interim DSH payments received and those hospitals whose audited hospital specific DSH limits exceed their interim DSH payments received during the Medicaid State Plan rate year being audited.

3. Finally, to ensure compliance with Section 1923 (j) of the Social Security Act, the Medicaid Agency will recover any interim DSH payments in excess of the audited hospital specific DSH limits of those DSH hospitals under DSH pools (1) and (3).

i. These overpayment amounts within each DSH pool will then be summed and redistributed to those eligible DSH hospitals within DSH pools (1) and (3) whose audited hospital specific DSH limits exceed their interim DSH

payments received during the Medicaid State Plan rate year being audited.

ii. A redistribution percentage will be determined by taking the amount of the total DSH overpayments identified in item (i),adjusted for changes in FFP rates, and dividing by the sum of the remaining balances of the unreimbursed hospital specific DSH limits of those eligible DSH hospitals.

iii. DSH hospitals eligible for redistribution funds as identified in item (i) will receive a portion of the recouped overpayments equal to the redistribution percentage calculated in item (ii) multiplied by the difference between each hospital's audited hospital specific DSH limit and interim DSH payment received by that hospital for the Medicaid State Plan year being audited.

iv. In the event that the audited hospital specific DSH limits in DSH pool (1) do not support the amount of the interim DSH payments received by the hospitals within the pool, the DSH overpayments recovered will transfer to DSH pool (3) for redistribution purposes. The interim DSH payments for hospitals contained within DSH pool (2) will be considered settled as paid.

c. Medical audits will focus on the validity of diagnosis and procedure coding for reconciliation of appropriate expenditures made by the SCDHHS as described in A of this section.