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State/Territory Name: South Carolina

State Plan Amendment (SPA) #: 22-0020

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S3-14-28
Baltimore, Maryland 21244-1850

Financial Management Group

March 17, 2023

Robert M. Kerr
Director, Department of Health & Human Services
Post Office Box 8206
1801 Main Street
Columbia, SC 29202-8206

Reference: State Plan Amendment (SPA) SC-22-0020

Dear Director Kerr:

We have reviewed the proposed amendment to Attachments 4.19-A and 4.19-B of your Medicaid State Plan submitted under transmittal number (TN) 22-0020. This amendment updates methods and standards for establishing Medicaid Disproportionate Share Hospital (DSH) payments to qualifying DSH hospitals using the FY ending 2021 base year cost reporting period to calculate interim DSH payments; updates the inflation rate used to trend the DSH base year cost to the end of the 2021 calendar year; updates swing bed and administrative day rates based upon the October 1, 2022, redetermination of nursing facility payment rates; and updates the statewide outpatient hospital fee schedule relating to Vagus Nerve Stimulation codes.

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.

This is to inform you that Medicaid State plan amendment SC-22-0020 is approved effective January 1, 2023. The CMS-179 and the plan pages are attached.

If you have any additional questions or need further assistance, please contact James Francis at james.francis@cms.hhs.gov.

Sincerely,

[redacted]

Rory Howe
Director

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 22-0020

2. STATE: SC

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT: (●) XIX ( ) XXI

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: January 1, 2023
~~January 1, 2023; DSH FFY 2023~~

5. FEDERAL STATUTE/REGULATION CITATION

42 CFR Part 447, Subpart C

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2023 $ 32,400,000
b. FFY 2024 $ 32,500,000

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

Attachment 4.19-A, pages 22, 26a, 26a.2, 26d, 26g, 27, 28, 28a

Attachment 4.19-B, pages 1a, 1a.8, 1a.9

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

Attachment 4.19-A, pages 22, 26a, 26a.2, 26d, 26g, 27, 28, 28a

Attachment 4.19-B, pages 1a, 1a.8, 1a.9

9. SUBJECT OF AMENDMENT

Inpatient and Outpatient Hospital Changes Effective January 1, 2023 and Medicaid DSH Changes For FFY 2023

10. 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:

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME
Robert M. Kerr

13. TITLE
Director

14. DATE SUBMITTED
December 21, 2022

15. RETURN TO
South Carolina Department of Health and Human Services
Post Office Box 8206
Columbia, SC 29202-8206

FOR CMS USE ONLY

16. DATE RECEIVED
December 22, 2022

17. DATE APPROVED
March 17, 2023

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
January 1, 2023

19. SIGNATURE OF APPROVING OFFICIAL
[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
Rory Howe

21. TITLE OF APPROVING OFFICIAL
Director, Financial Management Group

22. REMARKS
On 3/13/23, South Carolina requested a pen-and-ink change to Block 4 to read "January 1, 2023." JGF

Instructions on Back

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.

January 1, 2019 - December 31, 2019	181.87
January 1, 2020 - December 31, 2020	192.04
January 1, 2021 - September 30,2021	201.15
October 1, 2021 - December 31,2022	201.86
January 1, 2023	216.17

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:

January 1, 2019 – December 31, 2019	202.21 (RX Per Diem 20.34)
January 1, 2020 - December 31, 2020	211.96 (RX Per Diem 19.92)
January 1, 2021 – September 30,2021	221.40 (RX Per Diem 20.25)
October 1, 2021 - December 31, 2022	222.11 (RX Per Diem 20.25)
January 1, 2023 -	236.42 (RX Per Diem 20.25)

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 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 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 use of the most recent Global Insight Indexes Based CMS Hospital PPS Market Basket in order to trend the base year cost to the FFY 2023 UPL demonstration period.

(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 use of the most recent Global Insight Indexes Based CMS Hospital PPS Market Basket in order to trend the base year cost to the FFY 2023 UPL demonstration period.

(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, 2021 Medicaid per diem rates multiplied by the HFY 2021 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.

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 for FFY 2023, base year cost will be trended accordingly using the most recent CMS Market Basket rates. Base year cost will be trended using the midpoint to midpoint methodology and the use of the most recent Global Insight CMS Hospital Prospective Reimbursement Quarterly Market Basket Indexes. Medicaid base year revenue will be adjusted accordingly, if applicable, to reflect changes made to SC Medicaid inpatient hospital reimbursement. 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.

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.

(1) Covered Medicaid inpatient hospital days used in the UPL calculation are reconciled to the SC MMIS.

(2) 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.

(3) 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.

(4) For payments made for FFY 2023, base year cost will be trended accordingly using the most recent CMS Market Basket rates. Base year cost will be trended using the midpoint to midpoint methodology and the use of the most recent Global Insight Based CMS Hospital Prospective Reimbursement Quarterly Market Basket Indexes. Medicaid base year revenue will be adjusted accordingly, if applicable, to reflect changes made to SC Medicaid inpatient hospital reimbursement. 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 2022, qualification data will be based upon each hospital's fiscal year 2020 cost reporting period.

1. Effective for the October 1, 2022 – September 30, 2023 (FFY 2023) 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, and all Medicaid managed care patients (including PACE Program participants). 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, and SC Medicaid managed care patients (including PACE Program participants). Due to certain provisions contained within the Federal Consolidated Appropriations Act of 2021, the FFY 2023 Medicaid Shortfall of the interim hospital specific DSH limits will exclude the costs of Medicaid-eligible patients with third-party sources of coverage, where the third-party source of coverage is the primary payer. 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.

Except for the SC Department of Mental Health (SCDMH) hospitals, for FFY 2023, 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, and Medicaid MCO enrollees will be determined by taking each hospital's fiscal year 2021 cost reporting period charges for each group listed above and multiplying that by the hospital's applicable FY 2021 unadjusted inpatient and outpatient hospital cost to charge ratios (i.e. Uninsured, Medicaid MCO, and Medicaid FFS) 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, 2021 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, and all Medicaid managed care patients to determine the total unreimbursed cost for each DSH hospital. HFY 2021 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.

ii) For FFY 2023, each SCDMH hospital's interim hospital specific DSH limit will be calculated using FYE June 30, 2021 cost report data for all of its Medicaid fee for service, uninsured, and Medicaid managed care enrollees. Each hospital's total allowable cost will be inflated from the base year to December 31, 2021 using the CMS Market Basket Index described in (A)(3) of this section. The inflated cost will be divided by total FYE June 30, 2021 acute care hospital days to determine a cost per day amount. This cost per day amount will be multiplied by the FYE June 30, 2021 acute care hospital days associated with all Medicaid fee for service, uninsured, and Medicaid managed care enrollees 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, and Medicaid managed care enrollees to determine the total unreimbursed cost of each DSH hospital. Medicaid fee for service and Medicaid managed care revenue will be adjusted to account for any Medicaid rate increase provided since the base year.

iii) For new SC general acute care hospitals which enter the SC Medicaid Program during the October 1, 2022 – September 30, 2023 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, 2022 through September 30, 2023 Medicaid State Plan rate year.

iv) For the FFY 2023 DSH payment period, 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.

v) Effective for the FFY 2023 DSH payment period, the SCDHHS will create three separate DSH pools for the calculation of the interim DSH payments effective October 1, 2022. 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 2023 DSH allotment for the SC defined rural hospitals as described in iv. above. Finally, the remaining DSH allotment amount for FFY 2023 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 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, 2022 – September 30, 2023 annual aggregate DSH payment amounts will not exceed the October 1, 2022 – September 30, 2023 annual DSH allotment amount.

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

FY 2021 2.4 %

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 X.(C)(I)(b) of Attachment 4.19-A.

Determination of the Statewide Outpatient Hospital Fee Schedule Rates:

The October 1, 2007 statewide outpatient hospital fee schedule rates for acute care and long term acute care hospitals will be based upon the allowable outpatient cost information of covered services from each acute care hospital's FY 2005 cost report. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of outpatient hospital services. The agency's fee schedule rate was set as of October 1, 2007 and is effective for services provided on or after that date. All rates are published on the agency's website at https://www.scdhhs.gov/provider-type/hospital-services-provider-manual-040105-edition-posted-032205. All contracting SC acute care hospitals as well as out of state contracting border hospitals with SC Medicaid fee for service inpatient claims utilization of at least 200 claims were used in this analysis. The source document for Medicaid allowable outpatient costs will be the CMS-2552, which is the Medicare/Medicaid cost report. Allowable Medicaid outpatient costs will be determined in accordance with the Provider Reimbursement Manual Publication 15. However, for clarification purposes, one hundred percent (100%) of the South Carolina general acute care hospital provider tax will be considered an allowable Medicaid cost. Outpatient 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 2005 SCDHHS Management and Administration Reporting System (MARS) paid claims summary data report for each acute care hospital identified above will also be used during the analysis.

- As filed total facility costs are identified from each facility's FY 2005 Worksheet B Part I (BI) CMS-2552 cost report. Total outpatient facility costs would include operating, capital, and direct medical education. CRNA costs identified under BI, column 20 are removed from allowable costs. Observation cost is reclassified.

- As filed total facility costs will be allocated to Medicaid outpatient hospital cost using the following method:

  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 reported on Worksheet D Part V for Medicaid outpatient ancillary charges) to yield total SC Medicaid outpatient ancillary costs. The SC Medicaid outpatient cost-to-charge ratio will be determined by taking the sum of the SC Medicaid outpatient ancillary costs and dividing this amount by the sum of the SC Medicaid outpatient covered ancillary charges. The SC Medicaid outpatient cost-to-charge ratio will then be multiplied by the facility's SC Medicaid covered outpatient charges as identified on the SCDHHS MARS summary paid claims data report to determine each hospital's allowable SC Medicaid outpatient cost for FY 2005.

- The allowable Medicaid outpatient costs are summed to determine the aggregate Medicaid outpatient costs for FY 2005. An aggregate Medicaid allowable cost target was established at 95% of allowable Medicaid outpatient costs.

- After establishing the FY 2005 aggregate Medicaid allowable cost target, several actuarial models were developed and FY 2005 outpatient claims were repriced to determine the uniform increase in the statewide outpatient fee schedule rates. In order to trend the rates to the period October 1, 2007 through September 30, 2008, a 3.5% annual trend factor was applied. As a result of these steps, the statewide outpatient fee schedule rates increased by 135% effective October 1, 2007.

- The October 1, 2007 statewide fee schedule was updated effective November 1, 2022 for the Vagus Nerve Stimulation code updates.

  Determination of Hospital Specific Outpatient Multipliers:
  In order to convert the statewide outpatient fee schedule rate payment into a hospital specific payment, an outpatient multiplier will be developed for each hospital. The outpatient multiplier will adjust the calculated statewide outpatient fee schedule claims payment to a hospital specific payment and will represent the projected outpatient costs calculated in accordance with Agency defined criteria effective

- Effective for discharges incurred on and after January 1, 2020, all SC defined rural hospitals will receive retrospective cost settlements equaling 100% of their SC Medicaid outpatient hospital reimbursable cost subject to the July 1, 2014 and October 1, 2015 normalization actions.

- Effective for services provided on and after October 1, 2021, the impact of the July 1, 2014 and October 1, 2015 normalization actions will be removed from those hospitals impacted by these actions as outlined in Bullet #4 of page 1 and Bullet #1 of page 1.1. of Attachment 4.19-B. Therefore effective for services provided on and after October 1, 2021, SC defined rural hospitals and qualifying burn intensive care unit hospitals will receive 100% of its allowable Medicaid reimbursable costs on a retrospective basis.

For clarification purposes, 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.

II. Upper Payment Limits:

Outpatient hospital reimbursement shall be made in accordance with the upper payment limit requirements defined in 42 CFR 447.321.

Non-State Owned Governmental and Private Outpatient 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 outpatient hospitals (i.e. for profit and non-governmental nonprofit facilities). State owned psychiatric hospitals do not provide outpatient hospital services so no UPL demonstration is warranted for this class:

The most recent HFY 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) Medicaid covered outpatient hospital ancillary charges are obtained from the Summary MARS outpatient hospital report. Data source – Summary MARS outpatient hospital report.

(2) Medicaid covered outpatient hospital ancillary cost is determined by multiplying covered Medicaid outpatient hospital ancillary charges as identified on worksheet D Part V, column 3, 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.

(3) The total Medicaid outpatient hospital cost determined in step (2) is then trended using the mid-year to mid-year inflation method and the use of the most recent Global Insight Indexes Based CMS hospital PPS Market Basket in order to trend the base year cost to the FFY 2023 UPL demonstration period.

(4) Total base year Medicaid outpatient hospital revenue is derived from each hospital's Summary MARS report based upon each hospital's cost reporting period. Data source – Summary MARS outpatient hospital report. Base year revenue will be adjusted accordingly to reflect any rate/payment methodology changes that may have occurred since and during the base year. For hospitals that receive retrospective cost settlements of the estimated revenue for the FFY 2023 payment period will be adjusted accordingly to reflect no more then trended cost as referenced in step (3).

(5) The Medicaid UPL compliance check is determined for each class by comparing the aggregate amounts as determined in (3) above to ensure that projected Medicaid outpatient hospital cost is equal to or greater than projected Medicaid outpatient hospital payments in step (4). In the event that aggregate Medicaid outpatient hospital payments exceed aggregate Medicaid outpatient hospital cost, the hospital specific outpatient multiplier for each facility will be established using the Medicaid cost as reflected in step (3).