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State/Territory Name: South Carolina

State Plan Amendment (SPA) #: 23-0005

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 21, 2024

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-23-0005

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) 23-0005. This amendment updates reimbursement methodology for South Carolina designated rural hospitals to a cost-based prospective methodology, eliminating retrospective cost settlements for all South Carolina–defined rural hospitals. Cost-based prospective payment rates will be based on the two-year average of each hospital's 2020 and 2021 payment data and applied as a percentage base rate adjustment to the current inpatient and outpatient fee schedules.

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-23-0005 is approved effective July 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 or Ysabel Gavino at maria.gavino@cms.hhs.gov.

Sincerely,

Rory Howe

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: 23-0005

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
July 1, 2023

5. FEDERAL STATUTE/REGULATION CITATION
42 CFR Part 447, Subpart C

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2023 $ 0
b. FFY 2024 $ 0

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

Attachment 4.19-A, pages 1, 2, 2a, 9, 25, ~~29,~~ 29a

Attachment 4.19-B, pages 1.1a, 1a.3, 1a.6, 1a.8

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*

Attachment 4.19-A, pages 1, 2, 2a, 9, 25, ~~29~~, 29a

Attachment 4.19-B, pages 1.1a, 1a.3, 1a.6, 1a.8

9. SUBJECT OF AMENDMENT

This SPA will update reimbursement methodology for SC designated rural hospitals to a cost based prospective methodology.

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
RMKerr

12. TYPED NAME
Robert M. Kerr

13. TITLE
Director

14. DATE SUBMITTED
September 29, 2023

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
September 29, 2023

17. DATE APPROVED
March 21, 2024

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
July 1, 2023

19. SIGNATURE OF APPROVING OFFICIAL
Rory Howe

20. TYPED NAME OF APPROVING OFFICIAL
Rory Howe

21. TITLE OF APPROVING OFFICIAL
Director, Financial Management Group

22. REMARKS

Blocks 7 and 8: Pen-and-ink change removing Attachment 4.19-A page 29 requested by state on 2/2/24. (JGF)

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 burn intensive care unit hospitals as defined in the plan.

2. a prospective reimbursement system for all other acute, SC designated rural hospitals 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.

4. An all-inclusive per diem reimbursement system for pediatric inpatient rehabilitation units or 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 HFY 2011 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.).

c. Reimbursement for out of state border general acute care hospitals with S.C. Medicaid fee for service inpatient claims utilization of at least 200 claims during its HFY 2011 cost reporting period and all S.C. non-general acute care hospitals (i.e. long term acute care hospitals, and free standing short-term psychiatric hospitals using a cost target established at 93%) will be based on a prospective payment system. However, Direct Medical Education (DME) costs (including the capital related portion) and Indirect Medical Education (IME) costs associated with interns/residents and allied health alliance training programs will no longer be considered an allowable Medicaid reimbursable cost for out of state border hospitals. The DME and IME cost component of the SC long term acute care hospitals and the SC freestanding short-term psychiatric hospitals associated with interns/residents and allied health alliance training programs will be recognized at eighty-seven.three percent (87.3%) of allowable SC Medicaid inpatient hospital DME costs (including the DME capital related portion) and IME costs during the rate setting process. Effective for discharges occurring on or after October 1, 2013, the November 1, 2012 base rate component of the out of state border general acute care hospitals with SC Medicaid fee for service utilization of at least 200 claims will be increased by 2.75%. Effective for discharges occurring on or after October 1, 2014, the base rate component of the July 1, 2014 per discharge rate of those hospitals impacted by the July 1, 2014 rate normalization action or the base rate component of the October 1, 2013 per discharge rate of those hospitals not impacted by the July 2014 rate normalization action of the out of state border general acute care hospitals with SC Medicaid fee for service utilization of at least 200 claims will be increased by 2.50%.

d. Effective for discharges occurring on or after October 1, 2014, all SC general acute care hospitals plusqualifying burn intensive care unit hospitals which contract with the SC Medicaid Program will receive prospective payment rates using a cost target established at 93%. However, the DME and IME cost component of these SC general acute care hospitals with intern/resident and allied health alliance programs will be allowed at eighty-seven. three percent (87.3%) of allowable SC Medicaid inpatient hospital DME (including the DME capital related costs) and IME costs during the rate setting process. Effective for discharges occurring on or after October 1, 2014, the base rate component of the July 1, 2014 per discharge rate of those hospitals impacted by the July 1, 2014 rate normalization action or the base rate component of the October 1, 2013 per discharge rate of those hospitals not impacted by the July 2014 rate normalization action of the SC general acute care hospitals other than the SC defined rural hospitals and qualifying burn intensive care unit hospitals will be increased by 2.50%.

e. Effective for discharges occurring on or after July 1, 2023, SC defined rural hospitals (see page 9) which include all SC Critical Access Hospitals (CAH); all SC hospitals located in the state’s Zip Code Tabulation Areas (ZCTAs) classified as Moderately Rural/Rural; all SC hospitals located in Primary Care Health Professional

Shortage Areas (HPSAs) for Total Population; SC hospitals located in Persistent Poverty Counties with ≤130 Licensed Beds; and SC hospitals located in Equally Rural/Urban ZCTAs with ≤90 Licensed Beds which contract with the SC Medicaid Program will be based on a cost based prospective payment rate based on the two-year average of each hospitals 2020 and 2021 payment data and applied as a percentage base rate adjustment to the October 1, 2015 inpatient fee schedule.

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

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

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

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

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

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

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

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

Effective October 1, 2016, an additional SC defined rural hospital criterion was created to include a SC hospital that is located within a “persistent poverty county” as defined in Public Law (P.L.) 112-74 that is not otherwise eligible for higher reimbursement.

Effective for discharges incurred on and after October 1, 2021, the agency will further protect rural hospitals in South Carolina by allowing hospitals located in a Large Rural Zip Code Tabulation Area (ZCTA) and Primary Care Health Professional Shortage Area (HPSA) for low-income population and has less than or equal to 130 beds to be eligible for retrospective Medicaid cost settlements and DSH reimbursement at 100% of their individual hospital-specific DSH limit. This additional rural hospital criteria will add two hospitals to the South Carolina Defined Rural Hospital list, Cherokee Medical Center and MUSC Health Kershaw Medical Center, and is based upon the results of the May 8, 2014, study conducted by the Division of Policy and Research on Medicaid and Medicare, Institute for Families in Society, University of South Carolina.

Effective for discharges incurred on and after July 1, 2023, South Carolina Defined rural hospitals will no longer receive retrospective Medicaid cost settlements and will receive a cost based prospective payment rate based on the two-year average of each hospitals 2020 and 2021 payment data applied as a percentage base rate adjustment to the October 1, 2015 inpatient fee schedule.

- Effective for discharges incurred on and after July 1, 2023, SC defined rural hospitals will no longer receive retrospective cost settlements and will receive a cost based prospective payment rate based on the two-year average of each hospitals 2020 and 2021 payment data applied as a percentage base rate adjustment to the October 1, 2015 inpatient fee schedule.

J. Graduate Medical Education Payments for Medicaid MCO Members

For clarification purposes, the SCDHHS will pay teaching hospitals for SC Medicaid graduate medical education (GME) cost associated with SC Medicaid MCO members. The managed care GME payment will be calculated the same as the medical education payment calculated by the fee-for-service program. It will be based on quarterly inpatient claim reports submitted by the MCO and the direct and/or indirect medical education add-on amounts that are paid to each hospital through the fee-for-service program. Payments will be made to the hospitals on a quarterly basis or less frequently depending on claims volume and the submission of the required data on the claim reports.

K. Co-Payment

Effective March 31, 2004, a standard co-payment amount of $25 per admission will be charged when a co-payment is applicable. The co-payment charged is in accordance with 42 CFR 447.53, 447.54(c) and 447.55. The inpatient cost settlement will include uncollected Medicaid co-payment amounts in accordance with 42 CFR 447.57.

L. Payment for Out of State Transplant Services

Payment for transplant services provided to South Carolina Medicaid recipients by out of state hospitals (i.e. other than the border hospitals of North Carolina and Georgia) will be based upon a negotiated price reached between the out of state provider and the Medicaid Agency. The negotiated price will include both the professional and the hospital component. Transplant services provided to Medicaid recipients in South Carolina DSH hospitals will be reimbursed in accordance with the payment methodology outlined in Attachment 4.19-A and 4.19-B (i.e. South Carolina general hospitals will be reimbursed allowable inpatient and outpatient costs in accordance with provisions of the plan while the physician professional services will be reimbursed via the physician fee schedule).

M. Adjustment to Payment for Hospital Acquired Conditions (HACs)

Effective for discharges occurring on or after July 1, 2011, the South Carolina Medicaid Agency will no longer reimburse hospitals for treatment related to Hospital Acquired Conditions as defined by Medicare. Therefore, while the current Grouper employed by the Medicaid Agency cannot adjust the interim fee for service claim payment, the HAC recoupment process will be implemented as part of the

Effective for discharges incurred on and after October 1, 2016, the following classes of SC defined rural hospitals will receive retrospective cost settlements at the following percentages subject to the July 1, 2014 and October 1, 2015 normalization actions:

- Hospitals designated as SC defined rural hospitals prior to October 1, 2014 will receive 100% of their SC Medicaid inpatient hospital reimbursable cost (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 the greater of interim Medicaid fee for service reimbursement or 90% of allowable Medicaid reimbursable inpatient hospital costs, but not to exceed 100% of allowable Medicaid reimbursable costs (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 the greater of interim Medicaid fee for service reimbursement or 80% of allowable Medicaid reimbursable inpatient hospital costs, but not to exceed 100% of allowable Medicaid reimbursable costs (The Regional Medical Center).

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 inpatient hospital reimbursable cost subject to the July 1, 2014 and October 1, 2015 normalization actions.

Effective for discharges incurred on and after October 1, 2021, all SC defined rural hospitals will receive retrospective cost settlements equaling 100% of their SC Medicaid inpatient hospital reimbursable cost.

Effective for discharges incurred on and after July 1, 2023, all SC defined rural hospitals will receive a cost based prospective payment rate based on the two-year average of each hospitals 2020 and 2021 payment data applied as a percentage base rate adjustment to the October 1, 2015 inpatient fee schedule.

Effective October 1, 2016, an additional SC defined rural hospital criterion was created to include a SC hospital that is located within a "persistent poverty county" as defined in Public Law (P.L.) 112-74 that is not otherwise eligible for higher reimbursement.

Effective for services provided on and after October 1, 2021, the agency will further protect rural hospitals in South Carolina by allowing hospitals located in a Large Rural Zip Code Tabulation Area (ZCTA) and Primary Care Health Professional Shortage Area (HPSA) for low-income population and has less than or equal to 130 beds as a SC defined rural hospital. This additional rural hospital criteria will add two hospitals to the South Carolina Defined Rural Hospital list, Cherokee Medical Center and MUSC Health Kershaw Medical Center, and is based upon the results of the May 8, 2014, study conducted by the Division of Policy and Research on Medicaid and Medicare, Institute for Families in Society, University of South Carolina.

Effective for services provided on and after July 1, 2023, South Carolina Defined rural hospitals will no longer receive retrospective Medicaid cost settlements and will receive a cost based prospective payment rate based on the two-year average of each hospitals 2020 and 2021 payment data applied as a percentage base rate adjustment to the October 1, 2015 outpatient fee schedule.

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

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

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

Effective October 1, 2016, an additional SC defined rural hospital criterion was created to include a SC hospital that is located within a "persistent poverty county" as defined in P.L. 112-74 that is not otherwise eligible for higher reimbursement.

Effective for services provided on and after October 1, 2021, the agency will further protect rural hospitals in South Carolina by allowing hospitals located in a Large Rural Zip Code Tabulation Area (ZCTA) and Primary Care Health Professional Shortage Area (HPSA) for low-income population and has less than or equal to 130 beds as a SC defined rural hospital. This additional rural hospital criteria will add two hospitals to the South Carolina Defined Rural Hospital List, Cherokee Medical Center and MUSC Health Kershaw Medical Center, and is based upon the results of the May 8, 2014, study conducted by the Division of Policy and Research on Medicaid and Medicare, Institute for Families in Society, University of South Carolina.

Therefore, effective for services provided on or after October 1, 2014, the base portion of the September 30, 2014 hospital specific outpatient multiplier for all SC general acute care hospitals that qualify as rural as well as qualifying burn intensive care unit hospitals was increased by 2.50%. However, for SC general acute care teaching hospitals as defined in Attachment 4.19-A, the DME portion of the hospital specific outpatient multiplier was not subject to the 2.50% increase.

Effective for services provided on and after July 1, 2023, South Carolina Defined rural hospitals will receive a cost based prospective payment rate based on the two-year average of each hospitals 2020 and 2021 payment data applied as a percentage base rate adjustment to the October 1, 2015 outpatient fee schedule.

Hospital Specific Outpatient Multiplier Calculation Effective On and After November 1, 2012

The following methodology is employed in the computation of the hospital specific outpatient multiplier effective November 1, 2012:

a) The hospital specific outpatient multipliers will continue to be calculated so that outpatient hospital reimbursement approximates the Department's specified percent of allowable Medicaid costs for each eligible hospital as described under the section titled "Determination of Hospital Specific Outpatient Multipliers".

b) A cost to charge ratio will be calculated for Medicaid outpatient hospital services. This ratio will be calculated using cost from worksheet B Part 1 Column 24, charges from worksheet C Column 8, and Medicaid cost settled ancillary charges obtained from the Medicaid Management and Administration Reporting System (MARS) identified on worksheet D part V column 3. The Medicaid outpatient hospital 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 covered outpatient ancillary charges. Charges not covered by the hospital payment system, such as CRNA and ambulance, must be excluded from this calculation. Effective for services provided on or after July 11, 2011, two cost to charge ratios will be determined for teaching hospitals. The first cost to charge ratio will be determined

(Direct Medical Education) component of the hospital specific outpatient multipliers will not be impacted by this change. For hospitals whose hospital specific outpatient multiplier falls below the 15th percentile, these hospitals will be reimbursed at the 15th percentile hospital specific outpatient multiplier. However, any teaching hospital whose hospital specific outpatient multiplier falls below the 15th percentile will continue to receive its October 1, 2014 hospital specific outpatient multiplier. For all other hospitals that did not receive a hospital specific outpatient multiplier, an outpatient multiplier of .93 will be assigned to those hospitals. The hospital specific outpatient multiplier determined above will be applied after the fee schedule payment has been calculated prior to any reduction for third party liability and coinsurance.

j) 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.

k) Effective for services provided on and after July 1, 2023, South Carolina Defined rural hospitals will receive a cost based prospective payment rate based on the two-year average of each hospitals 2020 and 2021 payment data applied as a percentage base rate adjustment to the October 1, 2015 outpatient fee schedule.

Clinical Lab Fee Schedule:

Effective October 1, 2010, all outpatient hospital clinical lab services provided by governmental and private hospitals will be reimbursed at one hundred percent (100%) of the 2010 Medicare Clinical Lab Fee Schedule rates for the State of South Carolina. Effective for services provided on or after October 1, 2011, all outpatient hospital clinical lab services except for those provided by hospitals identified as SC critical access hospitals, SC isolated rural and small rural hospitals, certain SC large rural hospitals located in a Health Professional Shortage Area (HPSA) for primary care for total population, SC large rural hospitals as defined by Rural/Urban Commuting Area classes with an average of 35 full time equivalent occupied beds or less based upon hospital fiscal year 2008 thru 2011 cost report census data or qualifying burn intensive care unit hospitals will be reimbursed at ninety percent (90%) of the 2010 Medicare Clinical Lab Fee Schedule rates for the state of South Carolina. SC critical access hospitals, SC isolated rural and small rural hospitals, certain SC large rural hospitals located in a Health Professional Shortage Area (HPSA) for primary care for total population, SC large rural hospitals as defined by Rural/Urban Commuting Area classes with an average of 35 full time equivalent occupied beds or less based upon hospital fiscal year 2008 thru 2011 cost report census data and qualifying burn intensive care unit hospitals will be reimbursed at ninety-seven percent (97%) of the 2010 Medicare Clinical Lab Fee Schedule rates for the State of South Carolina. Therefore, the hospital specific outpatient multiplier described above will no longer be applied in the determination of outpatient hospital clinical lab services reimbursement.

Retrospective Hospital Cost Settlement Methodology:

Effective October 1, 2013, the following methodology describes the outpatient hospital retrospective cost settlement process for qualifying hospitals. 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 costs. Effective October 1, 2010, outpatient hospital clinical lab services will no longer be retrospectively cost settled.

- A cost to charge ratio will be calculated for Medicaid outpatient claims. This ratio will be calculated using cost from worksheet B part I, charges from worksheet C, and Medicaid settlement data from worksheet D part V. 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 part V. Charges not covered by the hospital payment system, such as CRNA and ambulance, must be excluded from this calculation.

- 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.

- Effective for services provided on and after July 1, 2023, South Carolina Defined rural hospitals will receive a cost based prospective payment rate based on the two-year average of each hospitals 2020 and 2021 payment data applied as a percentage base rate adjustment to the October 1, 2015 outpatient fee schedule.

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. Effective July 1, 2023, only qualifying burn units are eligible for retrospective cost settlement.

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.