

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF SOUTH CAROLINAMETHODS 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 acute care hospitals as defined in the plan, non-state owned governmental long-term care psychiatric hospitals and Department of Mental Health long-term psychiatric hospitals
2. a prospective reimbursement system for all other acute and non-acute care hospitals providing inpatient hospital services and
3. a prospective payment reimbursement system for private psychiatric residential treatment services and a retrospective reimbursement system for state-owned governmental and non-state owned governmental psychiatric residential treatment services in accordance with the Code of Federal Regulations. However, effective for services provided on and after April 8, 2011, the non-state owned governmental psychiatric residential treatment facility's retrospective cost settlement will be limited to ninety-seven percent (97%) of allowable Medicaid costs.

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.

- a. Prospective payment rates will be reimbursed to contracting

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out-of-state acute care hospitals with SC Medicaid fee for service inpatient claim utilization of less than 200 claims during its cost reporting period.

- b. Reimbursement for out of state border general acute care hospitals with S.C. Medicaid fee for service inpatient claims utilization of at least 200 claims and all S.C. non-general acute care hospitals (i.e. long term acute care hospitals, free standing short-term psychiatric hospitals, and free standing long-term psychiatric hospitals) will be based on a prospective payment system that will be further limited to no more than one hundred percent of the hospital's allowable SC Medicaid inpatient cost. However, effective for discharges occurring on or after July 11, 2011 by contracting out of state border hospitals that have SC Medicaid fee for service inpatient claims utilization of at least 200 claims, an annual analysis will be performed each cost reporting year to ensure that Medicaid reimbursement does not exceed ninety-three percent (93%) of allowable SC Medicaid inpatient costs relating to base as well as all capital related costs except for the capital associated with Direct Medical Education (DME). 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. For inpatient hospital discharges occurring on or after July 11, 2011 by SC long term acute care hospitals, free standing short-term psychiatric hospitals, and free standing long-term psychiatric hospitals, an annual analysis will be performed each cost reporting year to ensure that Medicaid reimbursement does not exceed ninety-three percent (93%) of allowable SC Medicaid inpatient costs relating to base as well as all capital related costs except for the capital associated with DME. The DME and IME cost component of the SC long term acute care hospitals and the SC freestanding short-term and long-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 in this analysis.
- c) Effective for discharges occurring on or after July 11, 2011, all SC general acute care hospitals except those designated as SC critical access hospitals. SC isolated rural and small rural hospitals as defined by Rural/Urban Commuting Area classes, certain SC large rural hospitals as defined by Rural/Urban Commuting Area classes and located in a Health Professional Shortage Area (HPSA) for primary care for total population, and qualifying burn intensive care unit hospitals which contract with the SC Medicaid Program will receive retrospective cost settlements, that, when added to fee for service and non fee for service payments (i.e. interim estimated cost settlements paid via gross adjustments), will represent ninety-three percent (93%) of each hospital's allowable SC Medicaid inpatient costs which includes both base costs as well as all capital related costs except for the capital associated with Direct Medical Education (DME). The DME and IME cost component of these SC general acute care hospitals with interns/residents and allied health alliance

will be retrospectively cost settled at eighty-seven.three percent (87.3%) of allowable SC Medicaid inpatient hospital DME (including the DME capital related costs) and IME costs. Effective for discharges incurred on or after October 1, 2011, SC large rural hospitals as defined by Rural/Urban Commuting Area classes with total licensed beds of 90 or less will be exempted from the July 11, 2011 payment reductions.

- d) Effective for discharges occurring on or after July 11, 2011, SC general acute care hospitals designated as SC critical access hospitals or those identified as SC isolated rural and small rural hospitals as defined by Rural/Urban Commuting Area classes will continue to receive retrospective cost settlements that represent ninety-seven percent (97%) of allowable SC Medicaid inpatient costs which includes base, capital, DME and IME costs. Additionally, certain SC large rural hospitals as defined by Rural/Urban Commuting Area classes and are located in a Health Professional Shortage Area (HPSA) for primary care for total population will continue to receive ninety-seven percent (97%) of allowable SC Medicaid inpatient costs which includes base, capital, DME and IME costs. Effective for discharges incurred on or after October 1, 2011, SC large rural hospitals as defined by Rural/Urban Commuting Area classes with total licensed beds of 90 or less will receive retrospective cost settlements that represent ninety-seven percent (97%) of allowable SC Medicaid costs which include base, capital, DME and IME costs.
- e) All qualifying hospitals that employ a burn intensive care unit and contract with the SC Medicaid Program will receive an annual retrospective cost settlement for inpatient services provided to SC Medicaid patients. Effective for discharges occurring on or after July 11, 2011, the retrospective cost settlement amount for qualifying hospitals with a burn intensive care unit will continue to be limited to ninety-seven percent (97%) of allowable SC Medicaid inpatient costs which includes base, capital, DME and IME costs. In order for a hospital to qualify under this scenario, a hospital must:
- a. Be located in South Carolina or within 25 miles of the South Carolina border;
 - b. Have a current contract with the South Carolina Medicaid Program; and
 - c. Have at least 25 beds in its burn intensive care unit.
- f) Retrospective inpatient cost settlements will be determined for all SC contracting non-state owned governmental long-term care psychiatric hospitals and all contracting SC long-term psychiatric hospitals owned by the SC Department of Mental Health. Retrospective cost settlements will be limited to one-hundred percent (100%) of allowable SC Medicaid inpatient costs.
2. Medicaid reimbursement to a hospital shall be payment in full. Hospitals may not separately bill the patient or the Medicaid program for medical services rendered during an inpatient stay, except as provided in Section III of this plan and/or coinsurance. Hospitals

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

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

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

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5. An outlier set-aside adjustment (to cover outlier payments described in 9 of this section) will be made to the per discharge rates.
6. Payment for services provided in freestanding long-term care psychiatric facilities shall be based on the statewide average per diem for psychiatric long-term care. The base per diem rate will be the statewide total costs of these psychiatric services divided by total psychiatric days.
7. The payments determined under both payment methods, the DRG payment system for general acute care hospitals, including acute psychiatric and rehabilitation units, long term acute care hospitals, and short term care psychiatric hospitals and the per diem method for psychiatric long-term care facilities, will be adjusted to recognize facility specific costs associated with direct and indirect medical education, capital and ancillary services as appropriate. In addition to the claims payment, hospitals may receive other payments as outlined in this Attachment. Some examples are as follows: Section VI I describes hospital cost settlements and Section VII describes Disproportionate Share Hospital payments.

Effective October 1, 1999, South Carolina Department of Mental Health hospitals will be reimbursed 100% of their allowable Medicaid inpatient cost through a retrospective cost settlement process. For clarification purposes, settlements will be determined on a per patient day basis. Effective October 1, 2010, non-state owned governmental long-term care psychiatric hospitals will be reimbursed 100% of their allowable Medicaid inpatient cost through a retrospective cost settlement process.

8. Special payment provisions, as provided in Section VI A of this plan, will be available under the DRG payment system for discharges which are atypical in terms of costs of services provided during the stay. These cases will be referred to as outliers. Special payment policies, as specified in Section VI B and C of this plan, will also be made for cases involving a transfer of a patient from one hospital to another, or a readmission of a patient following an earlier discharge. These provisions are not applicable to long-term psychiatric and RTF claims.
9. A rate reconsideration process will be available to hospitals that have higher costs as a result of conditions described in IX A of this plan.
10. Disproportionate share payments will be paid to qualifying hospitals in accordance with the requirements specified in Section VII of this plan.
11. Payment for services provided in psychiatric residential treatment facilities shall be an all-inclusive per diem rate. Section II paragraph 30 of this plan defines the costs covered by the all-inclusive rate. Each facility's per diem rate will be calculated using base year data trended forward. Section V B describes the rate calculation.
12. Effective for services provided on or after July 1, 2004, qualifying hospitals with burn intensive care units will receive annual retrospective cost settlements for the total cost of inpatient services provided to South Carolina Medicaid patients.

Effective for discharges occurring on and after April 8, 2011, the retrospective cost settlement amount for qualifying hospitals with a burn intensive care unit will be limited to ninety-seven percent (97%) of allowable SC Medicaid inpatient costs.

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

II. Definitions Applicable to Inpatient Hospital and Residential Treatment Facility Reimbursement

The following definitions will help in understanding the payment rates set for inpatient hospital and residential treatment facility services:

1. Administrative Days - The days of service provided to recipients who no longer require acute hospital care, but are in need of nursing home placement that is not available at the time. The patient must meet either intermediate or skilled level of care criteria.
2. Arithmetic Mean (average) - The product of dividing a sum by the number of its observations.
3. Base Year - The fiscal year used for calculation of payment rates. For the hybrid payment system rates effective on and after July 11, 2011, the base year shall be each facility's 2006 fiscal year. For the freestanding long-term psychiatric hospital rates, the base year shall be each facility's 1990 fiscal year.
4. Burn Intensive Care Unit Cost Settlement Criteria - In order to qualify for this cost settlement a hospital must satisfy all of the following criteria. A hospital must:
 - Be located in South Carolina or within 25 miles of the South Carolina border;
 - Have a current contract with the South Carolina Medicaid Program; and
 - Have at least 25 beds in its burn intensive care unit.
5. Capital - Cost associated with the capital costs of the facility. Capital costs include, but are not limited to, depreciation, interest, property taxes, property insurance, and directly assigned departmental capital lease costs. In no case shall the capital amount include amounts reflecting revaluation of assets due to change of ownership or leasing arrangement subsequent to September 1, 1984.
6. Case-Mix Index - A relative measure of resource utilization at a hospital.
7. Cost - Total SC Medicaid allowable costs of inpatient services, unless otherwise specified.
8. CRNA - Certified Registered Nurse Anesthetist.
9. Diagnosis Related Groups (DRGs) - A patient classification that reflects clinically cohesive groupings of patients who consume similar amounts of hospital resources.
10. Direct Medical Education Cost - Those direct costs associated with an approved intern and resident or nursing school teaching program as defined in the Medicare Provider Reimbursement Manual, publication HIM-15.

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11. Discharge - The release of a patient from an acute care facility. The following patient situations are considered discharges under these rules.
 - a. The patient is formally released from the hospital.
 - b. The patient is transferred to a long-term care level or facility.
 - c. The patient dies while hospitalized.
 - d. The patient leaves against medical advice.
 - e. In the case of a delivery, release of the mother and her baby will be considered two discharges for payment purposes. In case of multiple births, each baby will be considered a separate discharge.
 - f. A transfer from one hospital to another will be considered a discharge for billing purposes but will not be reimbursed as a full discharge except as specified in Section VI. Cases involving discharges from one unit and admission to another unit within the same or a different general acute care hospital shall be recognized as two separate discharges for reimbursement purposes. The DRG assignment for each case will be assigned based on services provided at the point of discharge.
12. Disproportionate Share Hospitals - South Carolina and border state's (Georgia and North Carolina) contracting acute care inpatient hospitals whose participation in the SC Medicaid Program and services to low income clients is disproportionate to the level of service rendered in other participating hospitals shall be considered disproportionate share.

Effective October 1, 2008, hospitals must satisfy one of the following criteria in order to qualify for the SC Medicaid DSH Program:

1. Be a licensed SC general acute care hospital that contracts with the SC Medicaid Program or;
2. Be a SC psychiatric hospital that is owned by the SC Department of Mental Health that contracts with the SC Medicaid Program or;
3. Be a general acute care border hospital (in North Carolina or Georgia) with SC Medicaid fee for service inpatient claims utilization of at least 200 inpatient claims per year in the base year or any SC non-general acute care hospital that contracts with the SC Medicaid Program whose base year's Medicaid inpatient utilization rate is at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the State or whose base year's low-income utilization rate exceeds 25%.

In addition to the above criteria, hospitals must satisfy the next two criteria in order to qualify for the SC Medicaid DSH Program:

- a. Hospitals must have a Medicaid day utilization percentage of at least one percent.

- b. Hospitals must have at least two (2) obstetricians with staff privileges who have agreed to provide obstetrical services to Medicaid patients on a non-emergency basis. In the case of a hospital located in a rural area (as defined for purposes of section 1886 of the Social Security Act), the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures. This rule does not apply to a hospital that did not offer non-emergency obstetric services to the general population as of December 22, 1987.

Information pertaining to the base year(s) will be collected during the second and third quarter of the calendar year and will be used to determine which hospitals qualify for disproportionate share. Financial and statistical information used to determine disproportionate share qualification and payment will be submitted and/or verified on Medicaid supplemental worksheets. The supplemental worksheets must be completed correctly. Data will be verified by the DHHS using appropriate sources, including, but not limited to, the CMS 2552 and the DHHS inpatient MARS report and administrative days report. Disproportionate share eligibility does not qualify for the rate reconsideration process.

The disproportionate share payment methodology is set forth in Section VII A.

13. General Acute Care Hospital - An institution licensed as a hospital by the applicable South Carolina licensing authority and certified for participation in the Medicare (Title XVIII) program.
14. Geometric Mean - The measure of central tendency of a set of n values computed by extracting the nth root of the product of the values.

Example: The geometric mean of 2, 4 and 1 is $\sqrt[3]{2 \times 4 \times 1} = 2$

15. Indirect Medical Education Cost - Those indirect costs resulting from the additional tests and procedures performed on patients because the hospital is a teaching institution. Such costs are determined using the number of interns and residents per operating bed in a Federally derived indirect medical education equation.
16. Indirect Medical Education Percentage - The Medicare indirect medical education formula (adjusted to include psychiatric and rehab subprovider beds) is used to calculate indirect medical education cost. The formula used is as follows:

$C \times [(1 + (\text{interns and residents})/\text{beds})^{.405} - 1]$

17. Inpatient - A patient who has been admitted to a medical facility on the recommendation of a physician or a dentist and who is receiving room, board and professional services in the facility. A patient who is admitted to an acute care facility and expires while in the facility shall be considered an inpatient admission regardless of whether the stay was overnight.
18. Inpatient Services - Those items and services ordinarily furnished by a hospital for the care and treatment of patients. These items and services are provided under the direction of a licensed practitioner in accordance with hospital by-laws. Such inpatient services must be medically justified documented by the physician's records and must comply with the requirements of the state's designated Peer Review Organization (PRO). Emergency room services are included in the inpatient rate only when a patient is admitted from the emergency room.
19. Complex Care Services - Those services rendered to patients that meet the South Carolina Level of Care criteria for long term care and have multiple needs (i.e. two or more) which fall within the highest ranges of disabilities in the criteria.
20. Long-Term Care Psychiatric Hospital - An institution licensed as a hospital by the applicable South Carolina licensing authority, certified for participation in Medicare XVIII program, primarily engaged in providing psychiatric services for the diagnosis and treatment of mentally ill persons with a Medicaid inpatient acute average length of stay greater than twenty-five (25) days.
21. Low Income Utilization Rate - The sum of fractions a and b.

a. Numerator:

$$\frac{\text{Total Medicaid inpatient and outpatient charges, including charges for Medicaid managed care, dual (Medicare/Medicaid) eligible, and Medicaid with commercial insurance patients, plus cash subsidies for patient services received directly from state and local governments.}}{\text{Denominator:}}$$

Denominator:

$$\frac{\text{Total inpatient and outpatient charges (including cash subsidies) for patient services.}}{\text{Denominator:}}$$

b. Numerator:

$$\frac{\text{Total hospital charges for inpatient hospital services attributable to charity care less cash subsidies from "a" above.}}{\text{Denominator:}}$$

Denominator:

$$\frac{\text{Total inpatient charges for patient services.}}{\text{Cash subsidies are defined as monetary contributions or donations received by a hospital. These contributions must originate from state and local governments. All contributions received will be considered as cash subsidies. If the funds are not designated for a specific type of service (i.e. inpatient services), they shall be prorated based on each type of service revenue to the hospital's total revenue (i.e. total inpatient revenues divided by total patient revenues).}}$$

Cash subsidies are defined as monetary contributions or donations received by a hospital. These contributions must originate from state and local governments. All contributions received will be considered as cash subsidies. If the funds are not designated for a specific type of service (i.e. inpatient services), they shall be prorated based on each type of service revenue to the hospital's total revenue (i.e. total inpatient revenues divided by total patient revenues).

Charity care is defined as care provided to individuals who have no source of payment, third party or personal resources. Total charges attributable to charity care shall not include contractual allowances and discounts or charges where any payment has been received for services rendered. An individual application, client specific, must be taken and a decision rendered in each applicant's case.

22. Medicaid Day Utilization Percentage - A facility's percent of hospital Medicaid eligible inpatient acute days, including Medicaid managed care days, dual eligible (Medicare/Medicaid) days, and Medicaid with commercial insurance days plus administrative days divided by total hospital inpatient acute days plus administrative days. The source of patient day information will be the filed CMS-2552 worksheet S-3, DHHS's MARS report, DHHS's administrative days report and requested supplemental worksheets.
23. Medically Necessary Services - Services which are necessary for the diagnosis, or treatment of disease, illness, or injury, and which meet accepted standards of medical practice. A medically necessary service must:
 - a. Be appropriate to the illness or injury for which it is performed as to type and intensity of the service and setting of treatment;
 - b. Provide essential and appropriate information when used for diagnostic purposes; and
 - c. Provide additional essential and appropriate information when a diagnostic procedure is used with other such procedures.
24. Outlier - A cost outlier occurs when a patient's charges (converted to cost) exceed a specified amount above the base DRG payment. The hospital will receive reimbursement for the outlier in addition to the base DRG payment. The cost outlier payment methodology is described in Section VI of this plan.
25. Outpatient - A patient who is receiving services at a hospital which does not admit him/her and which is not providing him/her with room and board services.
26. Outpatient Services - Those diagnostic, therapeutic, rehabilitative, or palliative items or services furnished by or under the direction of a physician or dentist to an outpatient by an institution licensed and certified as a hospital. This service will include both scheduled services and the provision of service on an emergency basis in an area meeting licensing and certification criteria.
27. Principal Diagnosis - The diagnosis established after medical evaluation to be chiefly responsible for causing the patient's admission to the hospital.

28. Psychiatric Distinct Part - A unit where psychiatric services are provided within a licensed and certified hospital. Patients in these units will be reimbursed through the DRG payment system.
29. Psychiatric Residential Treatment Facility - An institution primarily engaged in providing psychiatric services for the diagnosis and treatment of mentally ill persons who require less than hospital services. Medicare certification is not required. Effective April 1, 1994 in-state psychiatric residential treatment facilities are required to be licensed by DHEC in order to receive Medicaid reimbursement as described in State Plan 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.

30. Psychiatric Residential Treatment Facility All-Inclusive Rate - The all-inclusive rate will provide reimbursement for all treatment related to the psychiatric stay, psychiatric professional fees, and all drugs prescribed and dispensed to a client while residing in the Residential Treatment Facility.
31. Rural/Urban Commuting Area (RUCA) Class - Rural/Urban Commuting Area classes are as defined by the University of Washington, Rural Health Research Center, 2006. ZIP Version 2.0, 2006 was used and aggregated RUCA codes, which reflect commuting patterns, were placed into four rural/urban classes - Urban, Large Rural, Small Rural, and Isolated Rural.
32. 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.
33. Special Care Unit - A unit as defined in 42 CFR 413.53 (d).
34. Standard Deviation - The square root of the sum of the squares of the deviation from the mean in a frequency distribution.
35. Teaching Hospital - A licensed certified hospital currently operating an approved intern and resident teaching program or a licensed certified hospital currently operating an approved nursing or allied health education program.

III. Services Included in the Hybrid Payment System

1. Acute Care Hospitals

The DRG payment system rates will include all services provided in an acute inpatient setting except:

- a. Professional component, including physician and CRNA services and any other professional fees excluded under Part A Medicare.
- b. Ambulance, including neonatal intensive care transport.

2. Psychiatric Residential Treatment Facilities

The per diem reimbursement rate will be the "all-inclusive" rate as defined in Section II, paragraph 30 of this plan.

IV. Data Sources and Preparation of Data for Computation of DRG Payment System Rates

Computation of DRG payment system rates under this plan will require the collection and preparation of the following data elements: per discharge DRG list including relative weights, Medicaid inpatient cost to charge ratios adjusted for April 8, 2011 and July 11, 2011 reimbursement changes, July 1, 2010 through June 30, 2011 incurred inpatient hospital claims with a run out date of August 5, 2011, hospital specific add-ons, case mix index, and an upcode adjustment factor.

A description of the source documents for the required data elements and the steps necessary for preparing the data for the rate computation described in Section V of this plan is presented in the following subsections.

A. Per Discharge DRG List

The DRG payment system will establish payment based upon a hospital specific and/or statewide average per discharge rate. Effective for discharges incurred on or after October 1, 2011, the Medicaid Agency will determine inpatient hospital claim payments based upon the DRG listing contained within version 28 of the APR-DRG grouper. Hospitals eligible to receive a hospital specific per discharge rate will include hospitals that are eligible to receive retrospective cost settlements (which are limited to the July 11, 2011 applicable percentages of allowable Medicaid reimbursable costs) and out of state border hospitals with SC Medicaid inpatient utilization of at least 200 inpatient claims during its HFY 2010 cost reporting period. Additionally, SC free standing short term psychiatric hospitals and SC long term acute care hospitals, with a minimum SC Medicaid inpatient utilization of at least 10 incurred claims during July 1, 2010 through July 31, 2011, will also receive a hospital specific per discharge rate. All other contracting/enrolled hospitals (i.e. out of state general acute care, new SC general acute care hospitals coming on line after 2010, and all other short term psychiatric and long term acute care hospitals) will receive the statewide average rate.

B. Allowable Inpatient Costs

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

1. As filed total facility costs are identified from each facility's FY 2010 Worksheet B Part I (BI) CMS-2552 cost report. Total inpatient facility costs would include operating, capital, direct medical education, and indirect medical education costs. Swing bed and Administrative Day payments are deducted from the adult and pediatric cost center on the CMS-2552 as well as CRNA costs identified under BI, column 20. Observation cost is reclassified.
2. As filed total facility costs will be allocated to Medicaid inpatient hospital cost using the following methods.
 - a. A cost-to-charge ratio for each ancillary service will be computed by dividing total costs as adjusted in this section by total charges as reported on Worksheet C. This cost-to-charge ratio will then be multiplied by SC Medicaid covered charges as (as reported on Worksheet DII or D-4 for Medicaid inpatient ancillary charges) to yield total SC Medicaid inpatient ancillary costs.
 - b. SC Medicaid routine service costs will be computed by dividing each routine cost center by total patient days of the applicable routine cost center and then multiplying by the applicable SC Medicaid covered patient days. Total SC Medicaid routine costs will represent the accumulation of the SC Medicaid cost determined from each applicable routine cost center.

3. The SC Medicaid inpatient cost-to-charge ratio, which reflects 100% of allowable Medicaid costs (including DME and IME) will be determined by taking the sum of the SC Medicaid routine service costs and inpatient ancillary costs and dividing this amount by the sum of the SC Medicaid covered routine service charges and inpatient covered ancillary charges.
4. Next, for non teaching hospitals, the inpatient hospital cost to charge ratio as determined in step 3. above will be reduced by either the April 8, 2011 payment reduction amount (i.e.3% of all costs) or by the July 11, 2011 payment reduction amount (i.e. 7% of all costs) as defined under Section I. (C), Overview of Reimbursement Principles, paragraphs (1) b., c., d., and e.
5. Next, for teaching hospitals as defined by the state plan, the inpatient hospital cost to charge ratio as determined in step 3. above will need to be broken out into two inpatient hospital cost to charge ratios consisting of base operating costs (including capita) and Graduate Medical Education costs (including Direct and Indirect). Therefore, Direct Medical Education costs as reported on worksheet B Part I are identified and removed from total allowable facility costs as reported under worksheet B, Part I, column 25 to determine base operating costs. Next, to determine the amount of Indirect Medical Education costs of teaching hospitals with an intern and resident training program, the base operating costs previously described will be multiplied by the Indirect Medical Education formula described in Section II 16. The amount of Indirect Medical Education costs as determined in this computation will be removed from base operating costs and then added to the amount of Direct Medical Education costs to determine Graduate Medical Education costs. Next, routine per diems and ancillary cost to charge ratios will be developed for both base operating costs and Graduate Medical Education costs based upon the methodology previously described in this section and multiplied by covered Medicaid inpatient hospital days and covered Medicaid inpatient ancillary charges to determine two Medicaid cost pools - one for base operating costs and one for Graduate Medical Education costs. Next, in order to determine the Medicaid allowable inpatient hospital cost, the individual cost pools will be reduced by either the April 8, 2011 payment reduction amount (i.e. 3% of all costs) or by the July 11, 2011 payment reduction amount (i.e. 7% on base and 12.7% or 0% on Graduate Medical Education costs) as defined under Section I. (C), Overview of Reimbursement Principles, paragraphs (1) b., c., d., and e. Finally, the two adjusted Medicaid cost pools will be summed and divided by total Medicaid inpatient hospital covered charges to determine the Medicaid inpatient hospital cost to charge ratio for use in the October 1, 2011 rate setting.

In a separate computation, a cost per day will be determined for prospective reimbursement to free-standing long-term care psychiatric facilities based on 1990 cost report data.

C. Inflation

1. DRG Payment System

For the DRG payment system rates effective October 1, 2011, no trend factor will be applied.

2. Free-Standing Long-Term Psychiatric Hospitals

For the freestanding long-term psychiatric hospital rates, the annual trend rates used to trend the FY 1990 SC Medicaid inpatient cost to the current rate period are as follows:

<u>Period</u>	<u>TEFRA Non-PPS Rate of Increase</u>
10/1/89 - 9/30/90	5.2%
10/1/90 - 9/30/91	4.4%
10/1/91 - 9/30/92	4.7%
10/1/92 - 9/30/93	4.7%
10/1/93 - 9/30/94	4.9%

Because these rates of increase are based on the Federal fiscal year, they will be adjusted to coincide with the State fiscal year.

The following calculations are performed to adjust FY 1990 costs to the reimbursement period.

- a. To compensate for varying fiscal year ends, each facility's 1990 fiscal year cost will be adjusted to reflect dollars as of a single point in time (12/31/90). For example, a facility with a 6/30 fiscal year end will have an additional inflation factor applied to its costs. This inflation factor will be calculated by dividing the number of days between 6/30 and 12/31 (184) by 365. The resulting percent will be multiplied by the applicable TEFRA Non-PPS factor. This factor will be calculated by adding 1.00 to the sum of the values derived from multiplying 5.2% times 9/12 (9 months of FY 1990) and multiplying 4.4% times 3/12 (3 months of FY 1991).
- b. A factor will be calculated to inflate costs from July 1, 1990 (midpoint of December 31, 1990 fiscal year) to January 1, 1994 (midpoint of June 30, 1994 fiscal year). Adding 1.00 to a through e below and then multiplying these numbers together calculate this factor.
 - i. $3/12 \times .052$
(three months of the FY 1990 rate of increase)
 - ii. $12/12 \times .044$
(twelve months of the FY 1991 rate of increase)

- iv. $12/12 \times .047$
(twelve months of the FY 1993 rate of increase)
- v. $3/12 \times .049$
(three months of the FY 1994 rate of increase)

This factor 1.173522 is applied to Medicaid cost in the rate calculation.

- 2. In subsequent rate years, the DHHS will inflate the long-term psychiatric hospital rates using either the DRI Hospital Market Basket, the TEFRA Non-PPS rate of increase or an inflation factor set by the DHHS.

The long-term psychiatric hospital base rates (excluding add-on components) shall be updated as follows employing the midpoint-to-midpoint inflation policy:

FY 1994-1995	0.0%
FY 1995-1996	6.0%
FY 1996-1997	0.0%
FY 1997-1998	4.0%
FY 1998-1999	0.0%
FY 1999-2000	15.0%
FY 2000-2001	1.0%
FY 2001-2002	7.0%
FY 2002-2003	0.0%
FY 2003-present	0.0%

D. DRG Relative Weights

The relative weights used for calculating reimbursement for hospitals paid under the DRG payment system will be the corresponding national relative weights (released in October 2010) of version 28 of the APR-DRG grouper. Relative weights will be reviewed annually and updated as needed at the same time as the DRG grouper is updated.

E. Medicaid Case-Mix Index

A case-mix index, which is a relative measure of a hospital's resource use, will be used to adjust the per discharge cost amounts to the statewide average case-mix. For each hospital the per discharge case-mix index will be computed by multiplying the number of incurred SC Medicaid inpatient claims during the period July 1, 2010 through June 30, 2011 by the DRG relative weight, summing these amounts and dividing by the sum of the total per case discharges. Version 28 of the APR-DRG grouper and the corresponding national relative weights (released in October 2010) were used in the calculation of the case mix index for each hospital.

F. Psychiatric Residential Treatment Facility Costs

Psychiatric residential treatment facility per diem reimbursement rates, effective for dates of service beginning on or after 09/01/98, shall be calculated using each facility's desk-reviewed cost report data reflecting allowable costs in accordance with CMS Publication 15-1 and the all-inclusive rate definition. Cost will come from each facility's 1997 CMS-2552 (Medicare/Medicaid Cost Report), with exception when applicable (e.g. professional service costs and subsequent period costs). If applicable, add-ons will be calculated and applied to the RTF rate for services required by the RTF program subsequent to the 1997 cost reporting period. These add-ons will be calculated using future cost report and/or budgeted cost and statistical data.

V. Reimbursement Rates

A. Inpatient Hospital

The computation of the hybrid payment system rates will require two distinct methods - one for computation of the hospital specific per discharge rates, and a second for computation of the statewide per diem rate for freestanding long-term care psychiatric facilities.

1. Hospital Specific Per Discharge Rates

The following methodology is employed in the computation of the hospital specific per discharge rates effective October 1, 2011:

- a. The hospital specific per discharge rates will continue to be calculated so that DRG based interim payments approximate the Department's specified percent of allowable Medicaid costs for each eligible hospital as described under section VI (I).
- b. The adjusted hospital fiscal year 2010 Medicaid inpatient hospital cost to charge ratio of each hospital, as described in Section IV. (B) (4) and (5), is multiplied by each hospital's Medicaid inpatient hospital covered charges based upon discharges incurred during the period July 1, 2010 through June 30, 2011.

- c. The Medicaid allowable inpatient cost determined in (b) above is reduced by three percent (3%) to determine the annual cost target to be used for each hospital eligible to receive a hospital specific rate. The three percent reduction is applied to take into account the difference between the cost report year and the claims data period.
- d. Next, as a starting point, an initial estimated hospital specific per discharge rate was established for each hospital and was used to reprice each hospital's incurred hospital claims for the period July 1, 2010 through June 30, 2011 using the payment criteria reflected below. The total claims payment amount for each hospital was then compared to each hospital's allowable cost target to determine whether to increase or decrease the initial estimated hospital specific per discharge rate. Model simulations were run for each hospital until each hospital's total claims payment amount, using the final hospital specific per discharge rate and the incurred inpatient hospital claims for the period July 1, 2010 through June 30, 2011, equaled each hospital's allowable cost target.
 1. DRGs as defined by version 28 of APR-DRG grouper as well as the corresponding national relative weights;
 2. Hospital specific case mix index as determined from the use of the grouper and relative weights as described in 1 above;
 3. The effect of the updated cost outlier payment methodology as well as updated cost outlier thresholds as outlined in Section VI (A) of the plan;
 4. Transfers and same day and one day stays reimbursed in accordance with Section VI (B and C) of the plan.
 5. An upcode adjustment factor of two percent (2%) was built within the October 1, 2011 per discharge rates.
- e. Next, once each teaching hospital's specific per discharge rate was determined in accordance with (d) above, the Direct Medical Education and Indirect Medical Education rate components for each hospital was developed by taking the calculated hospital specific per discharge rate and breaking the rate down into three components (i.e. base, DME, and IME) based upon the percentage of each hospital's base operating cost, DME cost and IME cost to total allowable facility costs.
- f. For all other hospitals that did not receive a hospital specific per discharge rate, a statewide per discharge rate was developed by first multiplying the base operating cost component of each hospital receiving a hospital specific per discharge rate by the total number of its discharges used in the October 1, 2011 rate setting (i.e. July 1, 2010 through June 30, 2011 incurred paid claims). Next, the sum of the calculated base operating cost amounts for all hospitals was divided by the sum of the discharges for all hospitals to determine the statewide per discharge rate effective October 1, 2011.
- g. The rate determined above is multiplied by the regular weight for that DRG to calculate the reimbursement for DRG claims.

SC 11-026
EFFECTIVE DATE: 10/01/11
RO APPROVAL: 10/23/12
SUPERCEDES: SC 11-014

2. Per Diem Prospective Payment Rate - Long-Term Psychiatric Facilities

Only freestanding long-term care psychiatric facilities are included in this computation.

- a. Adjusted Medicaid inpatient room and board costs are summed across all participating freestanding long-term care psychiatric facilities. The number of days of care is summed across these facilities and the result is divided into the total adjusted costs to yield the statewide average per diem.
- b. Hospital specific factors are added to the base rate, as was the case in Section V A. Medicaid days for freestanding long-term care psychiatric facilities are substituted in each computation for discharges. For freestanding long-term care psychiatric facilities providing ancillary services, an ancillary add-on is added to the base rate. The ancillary add-on is calculated in the same manner as the capital, DME and IME add-ons. The ancillary service adjustments that may be made will only apply to minor ancillary services such as drugs, medical supplies, etc. that may be identified separately within the provider's cost report and not combined within the routine cost center. Each long term care psychiatric hospitals allowable ancillary service cost will be determined individually on a per diem basis based upon its allowable costs and actual occupancy.
- c. To determine the amount of reimbursement for a particular claim, the number of certified days of stay is multiplied by the per diem rate for long-term care psychiatric services. No outlier payments will be made for reimbursement to long-term care psychiatric facilities. Effective for services provided on and after April 8, 2011, private and non-profit long-term care psychiatric facilities will receive ninety-seven percent (97%) of its October 1, 2010 rate. Effective for services provided on and after July 11, 2011, the long-term psych hospitals per diem rate will represent ninety-three percent (93%) of the October 1, 2010 per diem rate relating to base as well as all capital related costs except for the capital associated with Direct Medical Education (DME). 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 long term psych hospitals. SC long term psych teaching hospitals per diem rate will represent ninety-three percent (93%) of the October 1, 2010 per diem rate relating to base as well as all capital related costs except for the capital associated with Direct Medical Education (DME). DME costs (including the capital related portion) and Indirect Medical Education (IME) costs associated with interns/residents and allied health alliance training programs will be reimbursed at eighty-seven.three percent (87.3%) of the October 1, 2010 add-on amounts.
- d. Governmental long-term care psychiatric hospitals will not be impacted by this change.

SC 11-026
EFFECTIVE DATE: 10/01/11
RO APPROVAL: 10/23/12
SUPERCEDES: SC 11-014

is then applied against the "actual per discharge rate" determined in 1 e above to determine each component's portion of the "actual per discharge rate".

- f. A statewide per discharge rate will be established for teaching hospitals with an intern/resident program, teaching hospitals without an intern/resident program, and non-teaching hospitals. Hospitals that will receive the appropriate statewide per discharge rate will include long term acute care hospitals, freestanding short term psych hospitals, out of state contracting acute care hospitals with SC Medicaid fee for service inpatient claims utilization of less than 200 claims, new acute care hospitals that come on line after 2006, and contracting acute care hospitals with high cost/low SC Medicaid inpatient claim utilization. The October 1, 2010 statewide per discharge rate will be held to the October 1, 2008 payment rate. Effective for discharges occurring on and after April 8, 2011, the statewide per discharge rate will represent ninety-seven percent (97%) of the October 1, 2010 statewide per discharge rate. Effective for discharges occurring on and after July 11, 2011, the statewide per discharge rate will represent ninety-three percent (93%) of the October 1, 2010 "actual per discharge rate" relating to base as well as all capital related costs except for the capital associated with Direct Medical Education (DME). 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 hospitals. SC teaching hospitals per discharge rate will represent ninety-three percent (93%) of the October 1, 2010 "actual per discharge rate" relating to base as well as all capital related costs except for the capital associated with Direct Medical Education (DME). DME costs (including the capital related portion) and Indirect Medical Education (IME) costs associated with interns/residents and allied health alliance training programs will be reimbursed at eighty seven.three percent of the October 1, 2010 add-on amounts.
- g. The rate determined above is multiplied by the relative weight for that DRG to calculate the reimbursement for a per case DRG claim. Outlier amounts will be added if applicable.

B. Psychiatric Residential Treatment Facility

A per diem rate will be calculated for each South Carolina contracting psychiatric RTF. The rate will be calculated using allowable 1997 base year cost and statistical data as reported on the CMS 2552 cost report trended forward. The rate will cover all costs included in the "all-inclusive" rate definition. An occupancy adjustment will be applied if the base year occupancy rate is less than the statewide average occupancy rate. If applicable, add-ons may be applied to the RTF rate for services required by the RTF program subsequent to the 1997 cost reporting period. State government owned and operated facilities, non-state government owned and operated facilities and new facilities will receive special consideration as specified below.

Each facility's occupancy rate will be calculated. If a facility's occupancy rate is less than the statewide average RTF occupancy rate, the routine cost and physician cost (if separately identified) will be adjusted to reflect RTF days at the statewide average occupancy level. The ancillary cost centers (if separately identified) will not be subject to an occupancy adjustment and thus will be subject to the RTFs' actual occupancy rate. No occupancy adjustment will be made for state government owned and operated facilities and non-state government owned and operated facilities.

The 1997 base year psychiatric RTF costs will be inflated using the CMS Market Basket Indices. The base year cost will be inflated through 12/31 of the base year and then the midpoint-to-midpoint inflation method will be used to inflate the rates from the base year to the rate period. If applicable, add-ons will be inflated forward. The midpoint-to-midpoint inflation rates are as follows:

FY 1999-00	6.37%
FY 2000-01	11.43%
FY 2001-07	0.00%

Effective September 1, 2008, the psychiatric RTF rates will be increased by 7.12%. Effective for services provided on and after April 8, 2011, all non-state owned governmental and private psychiatric RTF rates will represent ninety seven percent (97%) of the October 1, 2010 psychiatric RTF rate.

1. Facility Rate (excluding state government owned and operated, non-state government owned and operated and new facilities).

For clarification purposes, the per diem reimbursement rate will be calculated in two steps and then summed. The per diem component relating to routine and physician costs (if separately identified) will be calculated by dividing the allowable base year cost by the greater of actual bed days or the occupancy adjusted bed days. The per diem component relating to ancillary costs (if separately identified) will be calculated by dividing the allowable base year cost by the facility's actual bed days. Inflation will be applied to the sum of the two components using the mid-year method. If applicable, add-ons may be applied to the RTF rate for services required by the RTF program subsequent to

the 1997 cost reporting period. These add-ons will be subject to an occupancy adjustment, if applicable, and will be inflated from the period the cost was incurred.

2. State Government Owned and Operated Facility Rate

The per diem reimbursement rate will be calculated by dividing total allowable cost by actual bed days. No occupancy adjustment will be made.

3. Non-State Government Owned and Operated Facility Rate

The per diem reimbursement rate will be calculated by dividing total allowable cost by actual bed days. No occupancy adjustment will be made.

4. New Facility Rate

RTFs enrolled in the SCDHHS Medicaid program subsequent to the 1997 base year will be reimbursed the statewide average RTF rate.

VI. Special Payment Provisions

A. Payment for Outlier Cases - Per Discharge DRG Cases

1. Payments in addition to the base DRG reimbursement are available to a facility for covered inpatient services provided to a Medicaid recipient if the following conditions are met.
 - a. The hospital's adjusted cost for a claim exceeds the sum of the DRG threshold and DRG reimbursement. For hospitals which receive its own hospital specific per discharge rate, the hospital's adjusted cost is derived by applying the adjusted hospital specific cost to charge ratio used in the October 1, 2011 rate setting to the hospital's allowed claim charges. For hospitals that receive the statewide average per discharge rate, the hospital's adjusted cost is derived by applying the adjusted statewide cost to charge ratio of .2879 effective October 1, 2011.
 - b. The cost outlier thresholds were calculated using the following methodology:
 - Inpatient hospital claims with a discharge date incurred during July 1, 2009 through June 30, 2010 served as the basis for the cost outlier threshold calculations.
 - Calculate the average cost and standard deviation for each DRG.
 - If a DRG has 25 or more stays, set the initial cost outlier threshold at the average cost plus two standard deviations.
 - For DRGs with 25 or more stays, calculate the median ratio of the calculated threshold to the average cost. The result from this dataset is 2.30.

SC 11-026

EFFECTIVE DATE: 10/01/11

RO APPROVAL: 10/23/12

SUPERCEDES: SC 11-014

3. Per Diem Prospective Payment Rate - Long-Term Psychiatric Facilities

Only freestanding long-term care psychiatric facilities are included in this computation.

- e. Adjusted Medicaid inpatient room and board costs are summed across all participating freestanding long-term care psychiatric facilities. The number of days of care is summed across these facilities and the result is divided into the total adjusted costs to yield the statewide average per diem.
- f. Hospital specific factors are added to the base rate, as was the case in Section V A. Medicaid days for freestanding long-term care psychiatric facilities are substituted in each computation for discharges. For freestanding long-term care psychiatric facilities providing ancillary services, an ancillary add-on is added to the base rate. The ancillary add-on is calculated in the same manner as the capital, DME and IME add-ons.
- g. To determine the amount of reimbursement for a particular claim, the number of certified days of stay is multiplied by the per diem rate for long-term care psychiatric services. No outlier payments will be made for reimbursement to long-term care psychiatric facilities. Effective for services provided on and after April 8, 2011, private and non-profit long-term care psychiatric facilities will receive ninety-seven percent (97%) of its October 1, 2010 rate. Effective for services provided on and after July 11, 2011, the long-term psych hospitals per diem rate will represent ninety-three percent (93%) of the October 1, 2010 per diem rate relating to base as well as all capital related costs except for the capital associated with Direct Medical Education (DME). 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 long term psych hospitals. SC long term psych teaching hospitals per diem rate will represent ninety-three percent (93%) of the October 1, 2010 per diem rate relating to base as well as all capital related costs except for the capital associated with Direct Medical Education (DME). DME costs (including the capital related portion) and Indirect Medical Education (IME) costs associated with interns/residents and allied health alliance training programs will be reimbursed at eighty-seven.three percent (87.3%) of the October 1, 2010 add-on amounts.
- h. Governmental long-term care psychiatric hospitals will not be impacted by this change.

SC 11-014

EFFECTIVE DATE: 07/01/11

RO APPROVAL: 02/08/12

SUPERCEDES: New Page

- For DRGs with between 24 and 5 stays, set the initial cost outlier threshold at the average cost times 2.30.
- For DRGs with fewer than 5 South Carolina stays but some stays in the national dataset, estimate the average cost of these DRGs at average national charges times 35%, which is a reasonable cost to charge ratio based upon South Carolina data. For these DRGs, set the initial cost outlier threshold at estimated average cost times 2.30.
- For DRGs with no stays in the national dataset, set the initial cost outlier threshold as the estimated average cost of a closely related DRG times 2.30.
- If the initial threshold is below \$30,000, set it at \$30,000. If the initial threshold is above \$90,000, set it at \$90,000. If the initial threshold is between \$30,000 and \$90,000, leave it as is.

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

- a. If the hospital discharge includes cost beyond the sum of the threshold and the DRG payment for the applicable DRG, an additional payment will be made to the provider for those costs. A special request by the hospital is not required in order to initiate this payment.
- b. Charges for any services identified through utilization review as non-covered services, will be denied and any outlier payment made for these services will be recovered.
- c. The additional payment amount for cost outlier shall be derived by multiplying 60% of the difference between the hospital's adjusted cost for the discharge less the threshold described in 1 b of this section less the DRG payment amount. The hospital's total payment for the case will be the DRG rate specified in Section V plus the outlier payment as described in this section.

B. Payment for Transfers

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

SC 11-026
EFFECTIVE DATE: 10/01/11
RO APPROVAL: 10/23/12
SUPERCEDES: SC 11-008

- a. A hospital inpatient will be considered "transferred" when the patient has been moved from one acute inpatient facility to another acute inpatient facility. Movement of a patient from the general acute care hospital to an acute care psychiatric or rehab unit (and/or vice versa) will also constitute a transfer.
 - b. A hospital that received a transfer and subsequently discharges that individual will be considered the discharging hospital. All other hospitals that admit the subsequently transferred patient during a single spell of illness will be considered transferring hospitals.
2. Payment to a freestanding long-term care psychiatric facility that transfers or discharges a patient will be based on its per diem payment in accordance with Section V.
 3. Payment to a general hospital for a transfer claim under the hybrid payment system will be as follows:
 - a. A hospital that transfers a patient will be paid a per diem rate for the appropriate DRG in accordance with Section V of this plan. The per diem rate for claims being paid per discharge is determined by dividing the hospital's total DRG payment rate as described in Section V by the average length of stay for that DRG.
 - b. A hospital that receives a transfer patient and subsequently discharges the patient will be paid the full payment for the appropriate DRG in accordance with Section V.
 4. Any hospital involved in the transfer of an individual, either as the transferring or as the receiving hospital, may also qualify for outlier payments as described in A of this section.

C. Payment for Readmission

1. Readmission to the same or another facility within 30 days of a previous discharge for the same DRG or a similar diagnosis shall be subject to utilization review. Payment to the facility of the first admission may be modified or denied if it is determined that the first admission involved a premature discharge that resulted in the readmission. This applies to both per diem and per discharge cases.
2. This section will not apply in cases where a patient leaves the hospital against medical advice.

D. Payment for Same-Day Discharges

Special payment provisions will apply for patients discharged on the same day they are admitted. In these cases the hospital will be paid one-half of the appropriate DRG day. This amount will be determined

SC 11-026

EFFECTIVE DATE: 10/01/11

RO APPROVAL: 10/23/12

SUPERCEDES: SC 11-014

by multiplying the applicable DRG relative weight by the hospital discharge rate and dividing by twice the average length of stay for the DRG. However, when a patient is admitted and discharged, and subsequently readmitted on the same day, the hospital will be paid only one per discharge or per diem payment as appropriate.

E. Payment for Swing Bed Days

Acute care facilities will be reimbursed for qualifying skilled and intermediate care Medicaid patients in accordance with the daily rate schedule shown below.

October 1, 2003 - September 30, 2004	116.13
October 1, 2004 - September 30, 2005	121.92
October 1, 2005 - September 30, 2006	129.16
October 1, 2006 - September 30, 2007	136.24
October 1, 2007 - September 30, 2008	141.52
October 1, 2008 - September 30, 2009	146.98
October 1, 2009 - September 30, 2010	153.57
October 1, 2010 - April 7, 2011	154.67
April 8, 2011 - October 31, 2011	150.03
November 1, 2011 -	150.53

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.

- 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 trended Alternative Reimbursement Method (ARM) rate for pharmaceutical services.

October 1, 2003 - September 30, 2004	123.57 (ARM 7.44)
October 1, 2004 - September 30, 2005	129.75 (ARM 7.83)
October 1, 2005 - September 30, 2006	136.99 (ARM 7.83)
October 1, 2006 - September 30, 2007	144.07 (ARM 7.83)
October 1, 2007 - September 30, 2008	149.71 (ARM 8.19)
October 1, 2008 - September 30, 2009	155.56 (ARM 8.58)
October 1, 2009 - September 30, 2010	162.55 (ARM 8.98)
October 1, 2010 - April 7, 2011	163.83 (ARM 9.16)
April 8, 2011 - October 31, 2011	158.92 (ARM 8.89)
November 1, 2011 -	159.42 (ARM 8.89)

- 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.

SC 11-026

EFFECTIVE DATE: 10/01/11

RO APPROVAL: 10/23/12

SUPERCEDES: SC 08-034

This per diem rate will represent payment in full and will not be cost settled.

G. Payment for One-Day Stay

Reimbursement for one-day stays (except deaths, false labor (565-1 to 565-4), normal deliveries (560-1 to 560-4 and 541-1 to 541-4) and normal newborns (640-1 to 640-4)) will be reimbursed a DRG per diem. A DRG per diem is equal to reimbursement for applicable DRG divided by the average length of stay for that DRG.

H. New Facilities/New Medicaid Providers

Payment rates for facilities that were not in operation or not contracting with the SC Medicaid Program during the base year will be determined as follows:

- a. For hospitals under the DRG payment system, the per discharge payment rate will be set at the applicable statewide average per discharge rate (i.e. teaching with intern/resident program, teaching without intern/resident program, and non-teaching).
- b. For freestanding long-term care psychiatric facilities, payment will be at the statewide average per diem for long term care psychiatric facilities plus projected capital and medical education costs as applicable.
- c. For Residential Treatment Facilities, payments will be based on a statewide average of all the RTF rates.

I. Retrospective Hospital Cost Settlements

Effective for services provided on or after October 1, 2007, the following types of hospitals will receive retrospective Medicaid inpatient cost settlements. In calculating these settlements, allowable cost and payments will be calculated in accordance with the methodology described in Section VIII.

- All SC general acute care hospitals contracting with the SC Medicaid Program that qualify for the SC Medicaid DSH Program will receive retrospective cost settlements that, when added to fee for service and non fee for service (i.e. adjustment) payments, will represent one hundred percent (100%) of each hospital's allowable SC Medicaid inpatient costs. However, effective for discharges occurring on or after July 11, 2011, all SC general acute care hospitals except those designated as SC critical access hospitals, SC isolated rural and small rural hospitals as defined by Rural/Urban Commuting Area classes, certain SC large rural hospitals as defined by Rural/Urban Commuting Area classes and located in a Health Professional Shortage Area (HPSA) for primary care for total population, and qualifying burn intensive care unit hospitals which contract with the SC Medicaid Program will receive retrospective cost settlements, that, when added to fee for service and non fee for service payments (i.e. interim estimated cost settlements paid via gross adjustments) other than payments authorized in Sections VI(N) or VI(O), will represent ninety-three percent (93%) of each hospital's allowable SC Medicaid inpatient costs which includes both base costs as well as all capital related costs except for the capital associated with Direct Medical Education (DME). The DME and IME cost component of these SC general acute care hospitals with

SC 11-022
EFFECTIVE DATE: 10/01/11
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SUPERCEDES: SC 11-014

interns/residents and allied health alliance training programs will be retrospectively cost settled at eighty-seven.three percent (87.3%) of allowable SC Medicaid inpatient hospital DME (including the DME capital related costs) and IME costs.

- Effective for discharges occurring on or after July 11, 2011, SC general acute care hospitals designated as SC critical access hospitals or those identified as SC isolated rural and small rural hospitals as defined by Rural/Urban Commuting Area classes will continue to receive retrospective cost settlements that represent ninety-seven percent (97%) of allowable SC Medicaid inpatient costs which includes base, capital, DME and IME costs. Additionally, certain SC large rural hospitals as defined by Rural/Urban Commuting Area classes and are located in a Health Professional Shortage Area (HPSA) for primary care for total population will continue to receive ninety-seven percent (97%) of allowable SC Medicaid inpatient costs which includes base, capital, DME and IME costs.
- Effective for discharges incurred on or after October 1, 2011, SC large rural hospitals as defined by Rural/Urban Commuting Area classes with total licensed beds of 90 or less will receive retrospective cost settlements that represent ninety-seven percent (97%) of allowable SC Medicaid costs which include base, capital, DME and IME costs.
- All qualifying hospitals that employ a burn intensive care unit that contract with the SC Medicaid Program will receive retrospective cost settlements that, when added to fee for service and non fee for service (i.e. adjustment) payments, will represent one hundred percent (100%) of each hospital's allowable SC Medicaid inpatient costs. However, effective for discharges occurring on or after July 11, 2011, the retrospective cost settlement amount for qualifying hospitals with a burn intensive care unit will continue to be limited to ninety-seven percent (97%) of allowable SC Medicaid inpatient costs which includes base, capital, DME and IME costs.
- All SC psychiatric hospitals owned by the SC Department of Mental Health contracting with the SC Medicaid Program that qualify for the SC Medicaid DSH Program will receive retrospective cost settlements that, when added to fee for service and non fee for service (i.e. adjustment) payments, will represent one hundred percent (100%) of each hospital's allowable SC Medicaid inpatient costs.
- Effective October 1, 2010, all non-state owned governmental long-term care psychiatric hospitals will receive retrospective cost settlements that, when added to fee for service and non fee for service (i.e. adjustment) payments, will represent one hundred percent (100%) of each hospital's allowable SC Medicaid inpatient costs.
- Effective October 1, 2010, contracting out of state border hospitals with SC Medicaid fee for service inpatient claims utilization of at least 200 claims, contracting SC long term acute care hospitals, and contracting SC short term and long term freestanding psychiatric hospitals (excluding SCDMH psychiatric hospitals and non-state owned governmental long-term care psychiatric hospitals) will not qualify for retrospective cost settlements. However, an annual analysis will be performed each cost reporting year to ensure that Medicaid reimbursement under the hybrid payment system does not exceed allowable Medicaid inpatient costs. However, effective for discharges occurring on or after July 11, 2011 by contracting out of state border hospitals that have SC Medicaid fee for service inpatient claims.

utilization of at least 200 claims, an annual analysis will be performed each cost reporting year to ensure that Medicaid reimbursement does not exceed ninety-three percent (93%) of allowable SC Medicaid inpatient costs relating to base as well as all capital related costs except for the capital associated with Direct Medical Education (DME). 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. For inpatient hospital discharges occurring on or after July 11, 2011 by SC long term acute care hospitals, free standing short-term psychiatric hospitals, and free standing long-term psychiatric hospitals, an annual analysis will be performed each cost reporting year to ensure that Medicaid reimbursement does not exceed ninety-three percent (93%) of allowable SC Medicaid inpatient costs relating to base as well as all capital related costs except for the capital associated with DME. The DME and IME cost component of the SC long term acute care hospitals and the SC freestanding short-term and long-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 in this analysis.

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

retrospective cost settlement process. During this process, the SC Medicaid Agency or its designee will identify those inpatient hospital claims with HACs using Grouper version APR-28 and reduce the covered Medicaid inpatient hospital claim charges used for cost settlement purposes by the percentage change in the relative weight.

Effective for discharges occurring on and after October 1, 2011, payment by DRG may be reduced based on the federal requirements for Medicaid HCAC categories. The APR-DRG software will ignore secondary diagnoses that meet the minimum requirements of the Medicaid HCAC criteria. The list of Medicaid HCAC categories will be reviewed and updated annually. Adjustments will be made during the cost settlement process so that hospital costs associated with Medicaid HCACs are not reimbursed by the Department using the methodology previously described above. Payment by DRG may be disallowed based on the federal requirements for OPPCs. Claims will be identified and subject to quality review when the services provided meet the minimum requirements of OPPCs (e.g., erroneous surgeries). The Medicaid OPPC list will be reviewed and updated annually.

SC 13-002

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N. Supplemental Enhanced Payment for Qualifying Non-State Government Operated Hospitals

Effective for dates of service on or after October 1, 2011, quarterly supplemental enhanced payments will be issued to qualifying hospitals for Medicaid fee-for-service inpatient hospital services rendered during the quarter. The payments to be made under this Section will be determined using the following methodology described below. No payment under this section is dependent on any agreement or arrangement for providers or related entities to donate money or services to a governmental entity.

Maximum aggregate payments to all qualifying hospitals in this group shall not exceed the available upper payment limit per Medicaid State Plan rate year (i.e. federal fiscal year). If the payments under this section of the state plan exceed this total maximum disbursement, the state will calculate the percentage by which the upper payment limit is exceeded and reduce the payment to each hospital calculated in Step #2 of this section of the state plan by the same percentage.

1. Qualifying Criteria. All non-state government operated hospitals in South Carolina that meet all of the following criteria as of the approval date of the State Plan Amendment implementing this Section (Transmittal Number 11-022) qualify for payments under this Section N:
 - a. The hospitals are part of a hospital system in South Carolina;
 - i. A hospital system is defined as two or more hospitals (as determined based on independent Medicaid provider numbers) located in South Carolina that share common ownership.
 - b. At least one hospital in the hospital system must be designated as a Trauma I or Trauma II hospital by the South Carolina Department of Health and Environmental Control;
 - c. All hospitals in the hospital system must be operated by a regional health service district in accordance with Sections 44-7-2150 through 44-7-2157 of the South Carolina Code of Laws;
 - d. At least one hospital in the hospital system must be designated as a Regional Perinatal Center by the South Carolina Department of Health and Environmental Control; and
 - e. At least one hospital in the hospital system must be located in a small urban county.
 - i. A small urban county is defined as a county in South Carolina with a population less than three-hundred and fifty thousand (350,000) residents, as measured by the U.S. Census Bureau's 2010 Decennial Census, which is designated as an urban county based on the hospital's Core Based Statistical Area in the Centers for Medicare and Medicaid Services' 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 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 2012 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, 2012, base year cost will be trended accordingly using CMS Market Basket rates and Medicaid base year revenue will be adjusted accordingly to reflect changes made to SC Medicaid inpatient hospital reimbursement since October 1, 2012. 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.

O. Supplemental Enhanced Payment for Qualifying Private Hospitals

Effective for dates of service on or after October 1, 2011, quarterly supplemental enhanced payments will be issued to qualifying hospitals for Medicaid fee-for-service inpatient hospital services rendered during the quarter. The payments to be made under this Section will be determined using the following methodology described below. No payment under this section is dependent on any agreement or arrangement for providers or related entities to donate money or services to a governmental entity.

Maximum aggregate payments to all qualifying hospitals in this group shall not exceed the available upper payment limit per Medicaid State Plan rate year (i.e. federal fiscal year). If the payments under this section of the state plan exceed this total maximum disbursement, the state will calculate the percentage by which the upper payment limit is exceeded and reduce the payment to each hospital calculated in Step #2 of this section of the state plan by the same percentage.

1. Qualifying Criteria. All private hospitals in South Carolina that meet all of the following criteria as of the approval date of the State Plan Amendment implementing this Section (Transmittal Number 11-022) qualify for supplemental payments under this Section O:
 - a. The hospitals are part of a hospital system in South Carolina;
 - i. A hospital system is defined as two or more hospitals (as determined based on independent Medicaid provider numbers) located in South Carolina that share common ownership.
 - b. At least one hospital in the hospital system must be designated as a Trauma I or Trauma II hospital by the South Carolina Department of Health and Environmental Control;
 - c. All hospitals in the hospital system must be recognized as a Joint Commission Top Performer for at least three Key Quality Measures, as reflected in the 2012 report from The Joint Commission;
 - d. At least one hospital in the hospital system must have an Advanced Certification as a Primary Stroke Center from The Joint Commission;
 - e. At least one hospital in the hospital system must be a large rural hospital; and
 - i. A large rural hospital is defined as a hospital that both has an average daily census of greater than fifty (50), according to the Centers for Medicare and Medicaid Services' May 2013 Public Use File, and is located in a county with a population of less than sixty thousand (60,000) as measured by the U.S. Census Bureau's 2010 Decennial Census.
 - f. At least one hospital in the hospital system must be located in a small urban county.
 - i. A small urban county is defined as a county in South Carolina with a population less than three-hundred and

SC 11-022

EFFECTIVE DATE: 10/01/11

RO APPROVAL: 10/10/14

SUPERCEDES: New Page

fifty thousand (350,000) residents, as measured by the U.S. Census Bureau's 2010 Decennial Census, which is designated as an urban 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 2012 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, 2012, base year cost will be trended accordingly using CMS Market Basket rates and Medicaid base year revenue will be adjusted accordingly to reflect changes made to SC Medicaid inpatient hospital reimbursement since October 1, 2012. 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 2012, qualification data will be based upon each hospital's fiscal year 2010 cost reporting period.

1. Effective October 1, 2011, the interim hospital specific DSH limit will be set as follows:

a. The interim hospital specific DSH limit for all 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 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 hospital specific DSH limit for all general acute care border hospitals (in North Carolina and Georgia) and SC non-general acute care hospitals contracting with the SC Medicaid Program will be equal to fifty percent (50%) 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 Clifton Gunderson) relating to the audits of the Medicaid DSH plans will be the guiding document that hospitals must use in providing the DSH data. The stand alone SCHIP Program named "Healthy Connections Kids" is operated as a managed care program during FFY 2010 and thus its costs will not be included in the calculation of the interim hospital specific DSH limit effective October 1, 2011.

Except for the SC Department of Mental Health (SCDMH) hospitals, for FFY 2012, 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 2010 cost reporting period charges for each group listed

above and multiplying that by the hospital's applicable FY 2010 unadjusted inpatient and outpatient cost to charge ratios (i.e. Medicaid and Medicare) 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, 2010 using the applicable CMS Market Basket Indices described in 4 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 SC uninsured patients, SC Medicaid fee for service, SC dual eligibles, SC Medicaid eligibles who have inpatient and outpatient hospital services reimbursed by a commercial carrier, and SC Medicaid managed care patients to determine the total unreimbursed cost for each DSH hospital. However, because of Medicaid fee for service payment reductions in April 2011 and July 2011, HFY 2010 Medicaid Managed Care Payments and Medicaid Managed Care DME payments will be reduced appropriately for each hospital based upon its specific payment reduction in April 2011 or July 2011.

- i) For FFY 2012, each SCDMH hospital's interim hospital specific DSH limit will be calculated using FYE June 30, 2010 cost report data for its SC uninsured, SC dual (Medicare/Medicaid) eligible, and SC 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, 2010 using the CMS Market Basket Indices described in (A) (2) of this section. The inflated cost will be divided by total FYE June 30, 2010 acute care hospital days to determine a cost per day amount. This cost per day amount will be multiplied by the FYE June 30, 2010 acute care hospital days associated with SC uninsured, SC dual eligible, and SC 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 SC uninsured patients, SC dual eligibles, and SC Medicaid eligibles who have inpatient and outpatient hospital services reimbursed by a commercial carrier to determine the total unreimbursed cost of each DSH hospital. In the event that any of the SCDMH hospitals provided inpatient hospital services for SC Medicaid managed care patients during FYE June 30, 2010, the previous methodology outlined above will be used to determine the unreimbursed Medicaid managed care cost to be added to the unreimbursed uninsured cost previously described.
- ii) For new S. C. general acute care hospitals which enter the SC Medicaid Program on or after October 1, 2011, their interim hospital specific DSH limits for the October 1, 2011 through September 30, 2012 Medicaid State Plan rate year (i.e. DSH payment period) will be based upon projected DSH

qualification, cost, charge and payment data that will be subsequently adjusted to reflect the audited DSH qualification, cost, charge and payment data resulting from the audit of the October 1, 2011 through September 30, 2012 Medicaid State Plan rate year.

- iv) The SCDHHS will create two separate DSH pools for the calculation of the interim DSH payments effective October 1, 2011. 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 the aggregate FFY 2010 base DSH allotment payment amounts of all of the SCDMH hospitals. Next, the remaining DSH allotment amount beginning October 1, 2011 will be available to the remaining DSH qualifying hospitals. In the event that the sum of the hospital specific DSH limits of the remaining DSH qualifying hospitals exceeds the remaining DSH payment amount beginning October 1, 2011, the hospital specific DSH limits will be decreased proportionately to ensure the hospital specific DSH limits are within the remaining October 1, 2011, DSH payment amount.
2. The October 1, 2011 - September 30, 2012 annual aggregate DSH payment amounts will not exceed the October 1, 2010 - September 30, 2011 annual aggregate DSH payment amounts less the savings realized from the reductions in the out-of-state border and SC non general acute care hospitals' hospital specific DSH limit calculation effective October 1, 2011.
3. Effective on or after November 1, 2011, the South Carolina Department of Health and Human Services established qualification criteria that will be used to determine those general acute care and long term acute care Disproportionate Share (DSH) hospitals that will be subject to a reduction in their federal fiscal year (FFY) 2011/2012 DSH payments. The qualification criteria will be developed using as filed hospital fiscal year (HFY) 2009 South Carolina Medicaid fee for service and uninsured individuals' total inpatient and outpatient hospital costs as well as South Carolina Medicaid Managed Care Organization (MCO) enrollees total inpatient and outpatient hospital costs which covers the period of July 1, 2008 through June 30, 2009. These costs, which will be deemed as "Medicaid Primary Costs", will be accumulated by hospital and then divided by each hospital's as filed FY 2009 total inpatient and outpatient hospital costs to determine its portion of total inpatient and outpatient hospital costs associated with providing services to low income individuals. A "Medicaid Primary Costs" statewide weighted average rate will be determined by taking the sum of the "Medicaid Primary Costs" and dividing it by the sum of the HFY 2009 total inpatient and outpatient hospital costs of all general acute and long term acute care DSH qualifying hospitals which filed a HFY 2009 cost report. All general acute care and long term acute care DSH qualifying hospitals falling under the

SC 11-027
EFFECTIVE DATE: 11/01/11
RO APPROVAL: 10/23/12
SUPERCEDES: SC 11-026

statewide average rate will be subject to the FFY 2011/2012 DSH payment reduction except for those general acute care and long term acute care DSH hospitals that were exempted from the July 11, 2011 Medicaid inpatient and outpatient hospital payment reductions (i.e. these hospitals will be exempted from the DSH payment reduction previously described). New general acute care and long term acute care DSH qualifying hospitals that received DSH payments for the first time beginning in FFY 2010/2011 will also be included in the FFY 2011/2012 DSH payment reduction. Each impacted general acute care and long term acute care DSH hospital will receive its proportionate share of the annual DSH payment reduction amount based upon its FFY 2010/2011 interim DSH payment amounts. The total FFY 2011/2012 DSH payment reduction, on an annual basis, will amount to \$8,736,559 and will be recovered prior to June 30, 2012. Upon completion of the FFY 2012 Medicaid DSH audit, the "Medicaid Primary Costs" statewide average rate will be recalculated based upon audited FFY 2012 data to finalize the hospitals subject to the \$8,736,559 DSH payment reduction for FFY 2012 using the methodology previously described.

4. The following CMS Market Basket indice will be applied to the hospitals' base year cost.

CY 2010

2.1%

- 5 All disproportionate share payments will be made by adjustments during the applicable time period.
6. Effective October 1, 2010, all interim DSH payments will become final once the redistribution of any excess DSH payments have been made based upon the findings of the October 1, 2010 through September 30, 2011 DSH audit. See section IX(C) (1) (b) for additional information.

B. Additional Requirements

Effective October 1, 2005, all qualifying DSH hospitals must adhere to the following rules for participation in the South Carolina Medicaid DSH Program.

1. Each hospital will be responsible for understanding the SC Medicaid DSH Program in order to provide the proper requested information required for DSH qualification and payment.
2. Each hospital agrees to participate in DSH data reviews conducted by SCDHHS and/or CMS, as well as audits of the DSH program data performed by an independent auditor hired by SCDHHS.

VIII. Retrospective Hospital Cost Settlement Methodology:

The following methodology describes the inpatient hospital cost settlement process for qualifying hospitals.

A. A cost-to-charge ratio will be calculated for Medicaid inpatient claims. This ratio will be calculated using cost from worksheet B part I, charges from worksheet C, Medicaid and total days from worksheet S-3 and Medicaid settlement data from worksheets D part V and E-3. For each routine cost center, a per diem cost will be determined by dividing the allowable cost as reported on worksheet B part I (after removing swing bed cost and reclassifying observation cost) by total days as reported on worksheet S-3. This per diem will then be multiplied by Medicaid days as reported on worksheet S-3 in order to determine Medicaid routine cost. For ancillary cost centers, a cost-to-charge ratio will be calculated by dividing cost as reported on worksheet B part I by total charges from worksheet C. Medicaid cost for each ancillary cost center will be determined by multiplying this ratio by Medicaid charges as reported on worksheet D part V. The cost-to-charge ratio will be determined by dividing the sum of the calculated Medicaid routine and ancillary cost by the sum of the Medicaid charges as reported on worksheet E-3 (routine) and D-4 (ancillary). 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 sets of routine cost per diems and ancillary cost to charge ratios will be determined for teaching hospitals. The first set of routine cost per diems and ancillary cost to charge ratios will be determined on base and all capital related costs except those associated with DME capital costs using the methodology previously described. The second set of routine cost per diems and ancillary cost to charge ratios will be determined using DME (including the capital portion of DME costs) and IME costs determined under the Medicare formula using the methodology previously described. The applicable reductions (i.e. 93% or 97% to base and capital and 0% or 87.3% to DME and IME) will be applied to the calculated cost for each cost pool and an adjusted cost to charge ratio will be determined.

Total allowable Medicaid cost prior to the application of the applicable cost recovery percentage will be determined at the time of cost settlement by multiplying the adjusted cost-to-charge ratio as calculated in A above, by Medicaid adjusted charges. Medicaid adjusted charges will be determined by multiplying covered Medicaid billed charges by the ratio of covered to billed days. (This will remove charges for patients that are not covered for their entire stay). Charges are also adjusted for non Mars Report adjustments such as claim refunds, third party recoveries, etc. This adjustment is calculated by multiplying the ratio of Mars Report covered charges to Mars Report covered payments by the sum of the non Mars Report adjustment amounts. This amount is subtracted (debit) or added (credit) as appropriate.

The interim retrospective cost settlement amount will be determined by subtracting payments received from the allowable adjusted cost determined above. The payment amount includes Mars report payments and non Mars Report adjustments that were processed during the cost reporting/settlement period. Examples of these adjustments are small hospital access payments, refunds associated with third party payments, interim cost settlement payments, etc. The payment amount does not include payments authorized in Sections VI(N) or VI(O) of the State Plan.

Interim estimated cost settlements will only be allowed in extraordinary circumstances. It will be the responsibility of the provider to request and document the need for the cost settlement which could include the submission of one, or a combination of, the following documentation:

1. a more current annual or a less than full year Medicare/Medicaid cost report;

SC 11-022

EFFECTIVE DATE: 10/01/11

RO APPROVAL: 10/10/14

SUPERCEDES: SC 11-014

2. an updated inpatient cost-to-charge ratio;
3. an analysis reflecting the financial impact of the reimbursement change effective on or after October 1, 2007.

The provider request will be reviewed by SCDHHS staff to determine if an interim settlement adjustment is justified based upon the best available information at the time.

- D. 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.

IX. Changes to the Hybrid Payment System Rates

A. Rate Reconsideration

1. Providers will have the right to request a rate reconsideration of the hospital specific per discharge rate if one of the following conditions has occurred since the base year:
 - a. An error in the facility's hospital specific per discharge rate calculation. Such request will include a clear explanation of the error and documentation of the desired correction.
 - b. Changes in the case-mix since the base year. Such requests will be accompanied by documentation of the case-mix change using DRG case-mix and severity of illness measures. Use of the DRG case-mix index alone is not satisfactory for rate reconsideration under this part.
 - c. Extraordinary circumstances, such as acts of God, occurring since the base year and as defined by the DHHS. Such requests will be submitted along with documentation that clearly explains the circumstance, demonstration that the circumstance was extraordinary and unique to that facility, and the expenses associated with the circumstance.
 - d. Significant increases in capital expenditures since the base year used to establish the hybrid payment rates. Examples would include major building renovations, major equipment purchases, or a replacement hospital.
 - e. The addition or deletion of a teaching program.
2. Rate reconsideration will not be available for the following:
 - a. The payment methodology, case-mix adjustment, relative weights, inflation indices, DRG classification system.
 - b. Inflation of cost since the base year.
 - c. Increases in salary, wages, and fringe benefits.
3. Rate reconsideration requests will be submitted in writing to the DHHS Division of Acute Care Reimbursements and will set forth the

reasons for the requests. Each request will be accompanied by sufficient documentation to enable the DHHS to act upon the request. Rate reconsiderations for errors in the facility's hospital specific per discharge rate will be submitted in writing within 30 days of the rate notification.

4. The provider will be notified of the DHHS's decision within 90 days of receipt of the completed requested.

5. Pending the DHHS's decision on a request for rate reconsideration, the facility will be paid the hospital specific per discharge rate currently in effect, as determined by the DHHS. If the reconsideration request is granted, the resulting new hospital specific per discharge rate will be effective the later date of:

a. The receipt of the request and supporting documentation or

b. The first date of the next rate year (i.e. October 1), should the rate reconsideration be granted before this date; or

c. The date on which the asset leading to the expenditure was placed into service.

6. In no case will a rate reconsideration revision be granted if it will result in a facility's reimbursement exceeding allowable Medicaid inpatient cost.

7. Requests and documentation will be kept in a facility file and may be automatically reviewed in the following year if it has been determined that the condition will continue to exist. The facility will be asked in future years to supply only necessary updated information.

8. Psychiatric residential treatment facilities may request a rate reconsideration within 30 days of receiving their rates. The rate reconsideration may be filed for the following circumstances:

a. An error in the facility's rate calculation.

b. Amended costs and statistics submitted within 30 days of the receipt of notification of rates.

B. Appeals

A provider may appeal the DHHS's decision on the rate reconsideration. The appeal should be filed in accordance with the procedural requirements of the South Carolina Administrative Procedures Act (SCAPA) and the DHHS's regulations.

X. Review and Reporting Requirements

A. Utilization Review Specific to Hybrid Payment Rates

1. Utilization Review will be conducted by the state or its designee. Utilization review conducted by the designee will be performed as outlined in the current contract.
2. Negative review findings are subject to payment adjustment. Hospitals that develop or show trends in negative review findings will be subject to educational intervention.

B. Cost Report Requirements

Cost report requirements under the hybrid payment system and retrospective reimbursement system will conform to Medicare cost reporting principles and use as their basis the Medicare Cost Report Form - CMS-2552. In addition, providers must comply with Medicaid specific cost report requirements as published by the DHHS.

1. Acute Care Hospitals

- a. All acute care hospitals contracting with the SC Medicaid program must submit the CMS-2552 cost report form within one hundred and fifty (150) days of the last day of their cost reporting period (or by the Medicare due date when an extension is granted by the Medicare program). The CMS-2552 cost report submitted to SC Medicaid should be the same as the cost report submitted to Medicare except for SC specific reporting requirements. Only hospitals with low SC Medicaid fee for service inpatient utilization (less than 10 inpatient claims) will be exempt from this requirement.
- b. Cost report data will be used for retrospective cost settlements, cost analysis and disproportionate share purposes. Cost report data will be also be used for future rate setting purposes.
- c. Administrative days and associated cost, charges and payments will be reported on a supplemental worksheet issued by the DHHS. These days, cost, charges and payments must remain separate from all other Medicaid reported data. There will be no settlement for administrative days.

2. Psychiatric Residential Treatment Facilities

All psychiatric residential treatment facilities will submit the CMS-2552 form as well as their financial statements. The CMS-2552 will be completed using each facility's fiscal year statistical and financial information. Each facility will be required to submit these documents within one hundred and fifty (150) days of the last day of their cost reporting period.

C. Audit Requirements

All cost report financial and statistical information, the medical information contained on claims and information contained on supplemental

worksheets such as the DSH survey, are subject to audit by the DHHS or its designee. The audited information will be used for future rate calculations, retrospective cost settlements, disproportionate share program requirements, utilization review contractor requirements and other analyses.

I. Hospital Cost Reports

All hospital cost reports will be desk audited in order to determine the SC Medicaid portion of each hospital's cost. This desk-audited data will be used in cost settlement and DSH payment calculations and will be subject to audit.

- a. Supplemental worksheets submitted by hospitals for the disproportionate share program will be reviewed for accuracy and reasonableness by DHHS. Beginning with the 2005 DSH period, the DSH program will undergo an audit by an independent auditor. The findings from these audits could result in educational intervention to ensure accurate reporting.
- b. As required by Section 1923(j) of the Social Security Act related to auditing and reporting of Disproportionate Share Hospital (DSH) payments, the Medicaid Agency will implement procedures to comply with the DSH hospital payments final rule issued in the December 19, 2008, Federal Register, with effective date of January 19, 2009, to ensure that the hospital specific DSH limits have not been exceeded. The redistribution methodology described below effective for the DSH payment periods beginning on and after October 1, 2011 will ensure that the final DSH payments received by each DSH hospital will not exceed its hospital specific DSH limit determined for the Medicaid State Plan Rate Year being audited.
 - First, SCDHHS will create three separate DSH pools. (1) - SC state owned governmental long term psych hospitals; (2) out of state border DSH qualifying hospitals; and (3) - SC qualifying DSH Hospitals.
 - Next, the SCDHHS will redistribute the interim DSH payments made to the hospitals contained within DSH pools (1) and (3) based upon the audited hospital specific DSH limits contained within the DSH audit report for the Medicaid State Plan Rate Year being audited. The final DSH payment amounts for hospitals contained within DSH pools (2) and (3) will be calculated in accordance with the methodology contained within Section VII(a) (1) (a) (iv) of Attachment 4.19-A, less an DSH payments made to hospitals contained within DSH pool (2). The DSH payments for hospitals contained within DSH pool (2) will be considered settled as paid.

SC 11-026

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SUPERCEDES: SC 10-013

- In the event of DSH overpayments occurring within DSH pool (1), the overpayment amounts will be redistributed amount hospitals contained within DSH pool (3).
 - Once the final DSH payments have been determined for each of the qualifying DSH hospitals, the SCDHHS will compare the final DSH payment amount to the interim DSH payment amount previously reimbursed during the Medicaid State Plan Rate Year being audited. If a hospital has been overpaid, the SCDHHS will recoup one hundred percent of the overpayment from the hospital. If a hospital has been underpaid, the SCDHHS will reimburse the provider one hundred percent of the underpayment. However, no underpayments will be redistributed until all DSH overpayments have been recovered by the SCDHHS.
- c. Medical audits will focus on the validity of diagnosis and procedure coding for reconciliation of appropriate expenditures made by the DHHS as described in A of this section.

- d. Psychiatric Residential Treatment Facility (RTF) Cost Reports.
- i. All psychiatric RTF cost reports will be desk reviewed. This information may be used for future rate updates.
 - ii. There will be a retrospective cost settlement for state government owned and operated psychiatric RTFs and non-state government owned and operated psychiatric RTFs. These will be settled at 100% of allowable cost. However, effective for services provided on and after April 8, 2011, the non-state owned governmental psychiatric residential treatment facility's retrospective cost settlement will be limited to ninety-seven percent (97%) of allowable Medicaid costs.
 - iii. There will be no retrospective cost adjustment for RTFs that are paid the statewide average rate.
- e. Certified Public Expenditures incurred in providing services to Medicaid and individuals with no source of third party insurance.

The South Carolina Medicaid Agency uses the **CMS Form 2552-96** cost report for its Medicaid Program and all state owned/operated governmental psychiatric hospitals operated by the South Carolina Department of Mental Health (SCDMH) must submit this report each year. The Agency will utilize worksheet Series S, B, C, and D-4 to determine the cost of inpatient hospital services (no outpatient hospital services provided by SCDMH hospitals) provided to Medicaid eligibles and individuals with no source of third party insurance to be certified as public expenditures (CPE) from the **CMS Form 2552-96**.

This cost report will also be used to determine the cost of Psychiatric Residential Treatment Facility (PRTF) services provided by SCDMH. The Agency will use the procedures outlined below:

Cost of Medicaid

I. Interim Reconciliation of Interim Medicaid Inpatient Hospital Payments:

Upon receipt of the SCDMH hospitals' fiscal year end June 30 cost report, each hospital's interim Medicaid fee for service rate payments and any supplemental payments that may had been made which applied to services provided during the cost reporting period will be reconciled to its CMS Form 2552-96 cost report as filed to the Medicare Fiscal Intermediary (FI) and Medicaid Agency for the respective cost reporting period.

The State will determine each SCDMH hospital's Medicaid routine per diem cost by first summing the inpatient hospital routine service cost centers and dividing this amount by total inpatient hospital days. The routine service costs will be derived from worksheet B, Part I, column 25 (which includes GME cost, if applicable). Total inpatient hospital days and subprovider days (if applicable) will be obtained from Worksheet S-3, Part 1. Any subprovider cost identified as a non inpatient hospital cost (e.g. Psychiatric Residential Treatment Facility (PRTF)) will be excluded from the calculation of the inpatient hospital's routine cost. Next, in order to determine the Medicaid inpatient hospital ancillary service costs, Medicaid covered inpatient ancillary charges obtained from Medicaid worksheet D-4 will be multiplied

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by the applicable "cost" cost to charge ratio(s) by ancillary cost center reflected on Worksheet C. Therefore, to determine each hospital's allowable Medicaid inpatient hospital cost, the Medicaid routine per diem cost will be multiplied by covered Medicaid inpatient days to determine allowable Medicaid inpatient hospital routine costs. The Medicaid days are tied to MMIS paid claims data. The Medicaid allowable inpatient hospital routine cost will then be added to the allowable Medicaid inpatient ancillary costs to determine total allowable Medicaid inpatient hospital costs.

During the interim retrospective cost settlement process, the Medicaid inpatient hospital costs as determined above will be compared to Medicaid payments received and applicable (including both fee for service, gross adjustments, third party liability and copayments, if applicable) to services provided during the cost reporting period. The Medicaid days, charges and payments are tied to MMIS paid claims (including gross adjustment payment data). In the event of an underpayment, the Agency will reimburse the provider only the federal portion of the underpayment. In the event of an overpayment, the Agency will recover only the federal portion of the overpayment. Any difference to the reimbursement amount reflected above will be recorded as an adjustment on the CMS 64 report.

Final Reconciliation of Interim Medicaid Inpatient Hospital Payment Rate Post Reporting Year:

Upon issuance of a Final Audit Report by the Agency's audit contractor of the SCDMH hospital cost reports, the Agency will determine each SCDMH hospital's audited Medicaid routine per diem cost by first summing the inpatient hospital routine service cost centers and dividing this amount by total inpatient hospital days. The routine service costs will be derived from worksheet B, Part I, column 25 (which includes GME cost, if applicable). Total inpatient hospital days and subprovider days (if applicable) will be obtained from Worksheet S-3, Part 1. Any subprovider cost identified as a non inpatient hospital cost (e.g. Psychiatric Residential Treatment Facility (PRTF)) will be excluded from the calculation of the inpatient hospital's routine cost. Next, in order to determine the audited Medicaid inpatient hospital ancillary service costs, Medicaid covered inpatient ancillary charges obtained from Medicaid worksheet D-4 will be multiplied by the applicable "cost" cost to charge ratios by ancillary cost center reflected on Worksheet C. Therefore, to determine each hospital's audited Medicaid inpatient hospital cost, the audited Medicaid routine per diem cost will be multiplied by covered Medicaid inpatient days to determine the audited Medicaid inpatient hospital routine costs. The Medicaid days are tied to MMIS paid claims data. The audited Medicaid inpatient hospital routine cost will then be added to the audited Medicaid inpatient ancillary costs to determine total audited Medicaid inpatient hospital costs. The Agency will compare the audited allowable Medicaid inpatient hospital costs against the Medicaid payments received and applicable (including both fee for service, gross adjustments including interim retrospective cost settlements, third party liability and copayments, if applicable) to services provided during the cost reporting period. The Medicaid days, charges and payments that will be used in the final audit

SC 10-013

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SUPERCEDES: New Page

settlement will be tied to MMIS paid claims (including gross adjustment payment data). In the event of an underpayment, the Agency will reimburse the provider only the federal portion of the underpayment. In the event of an overpayment, the Agency will recover only the federal portion of the overpayment. Any difference to the reimbursement amount reflected above will be recorded as an adjustment on the CMS 64 report.

II. Interim Reconciliation of Interim Medicaid Psychiatric Residential Treatment Facility (PRTF) Payments:

Upon receipt of the SCDMH PRTF's fiscal year end June 30 cost report, the PRTF's interim Medicaid fee for service rate payments and any supplemental payments that may had been made which applied to services provided during the cost reporting period will be reconciled to its CMS Form 2552-96 cost report as filed to the Medicaid Agency for the respective cost reporting period.

The State will determine the SCDMH PRTF's Medicaid per diem cost by first identifying the routine cost of the PRTF (identified as a subprovider) in William S Hall's CMS Form 2552-96 cost report. This amount will be derived from worksheet B, Part I, column 25 (which includes GME cost, if applicable). Total PRTF (i.e. subprovider) patient days that will be used in the determination of the PRTF's Medicaid per diem cost will be obtained from Worksheet S-3, Part 1. Next, in order to determine the PRTF's portion of the ancillary service costs, Medicaid covered PRTF ancillary charges obtained from Medicaid worksheet D-4 will be multiplied by the applicable "cost" cost to charge ratio(s) by ancillary cost center reflected on Worksheet C. Therefore, to determine the PRTF's allowable Medicaid cost, the Medicaid PRTF per diem cost will be multiplied by covered Medicaid PRTF days to determine allowable Medicaid PRTF routine costs. The Medicaid days are tied to MMIS paid claims data. The Medicaid allowable PRTF routine cost will then be added to the allowable Medicaid PRTF ancillary costs to determine total allowable Medicaid PRTF costs.

During the interim retrospective cost settlement process, the Medicaid PRTF costs as determined above will be compared to Medicaid payments received and applicable (including both fee for service, gross adjustments, third party liability and copayments, if applicable) to services provided during the cost reporting period. In the event of an underpayment, the Agency will reimburse the provider only the federal portion of the underpayment. In the event of an overpayment, the Agency will recover only the federal portion of the overpayment. Any difference to the reimbursement amount reflected above will be recorded as an adjustment on the CMS 64 report.

Final Reconciliation of Interim Medicaid Psychiatric Residential Treatment Facility (PRTF) Payment Rate Post Reporting Year: Upon issuance of a Final Audit Report by the Agency's audit contractor of the SCDMH hospital/PRTF cost reports, the Agency will determine the SCDMH PRTF's audited Medicaid routine per diem cost by first identifying the PRTF's routine service cost center and dividing this amount by total PRTF patient days. The PRTF routine service cost will be derived from worksheet B, Part I, column 25 (which includes GME cost, if applicable). Total PRTF patient days

will be obtained from Worksheet S-3, Part 1. Next, in order to determine the audited Medicaid PRTF ancillary service costs, Medicaid covered PRTF ancillary charges obtained from Medicaid worksheet D-4 will be multiplied by the applicable "cost" cost to charge ratios by ancillary cost center reflected on Worksheet C. Therefore, to determine the PRTF's audited Medicaid cost, the audited Medicaid PRTF routine per diem cost will be multiplied by covered Medicaid PRTF patient days to determine the audited Medicaid PRTF routine costs. The Medicaid days are tied to MMIS paid claims data. The audited Medicaid PRTF routine cost will then be added to the audited Medicaid PRTF ancillary costs to determine total audited Medicaid PRTF costs. The Agency will compare the audited Medicaid PRTF costs against the Medicaid payments received and applicable (including both fee for service, gross adjustments including interim retrospective cost settlements, third party liability and copayments, if applicable) to services provided during the cost reporting period. The Medicaid days and payments, including claim and gross adjustment payments, that will be used in the final audit settlement will be tied to MMIS paid claims data. In the event of an underpayment, the Agency will reimburse the provider only the federal portion of the underpayment. In the event of an overpayment, the Agency will recover only the federal portion of the overpayment. Any difference to the reimbursement amount reflected above will be recorded as an adjustment on the CMS 64 report.

Cost of the uninsured

III. Calculation of Interim Disproportionate Share Hospital (DSH) Limit:

A base year will be used to calculate the cost of the SC uninsured, Medicaid managed care enrollees, dual (Medicare/Medicaid) eligibles, and Medicaid eligibles who have inpatient hospital services reimbursed by a commercial insurance carrier. The base year will be the SCDMH hospitals fiscal year end beginning two years prior to the reporting year (ex. 2009 data for federal fiscal year (FFY) 2011 DSH payments). Due to Medicaid services within the State for hospitals eligible to certify public expenditures being certified at cost, there will be no uncompensated care for these services. Therefore, the Interim DSH Limit for each SCDMH hospital will be the estimated uncompensated care for inpatient hospital services provided to SC individuals with no source of third party insurance (i.e. uninsured) plus the uncompensated care (including potential surplus) for inpatient hospital services provided to Medicaid managed care enrollees, dual (Medicare/Medicaid) eligibles, and Medicaid eligibles who have inpatient and outpatient hospital services reimbursed by a commercial carrier.

This computation of establishing interim DSH payments funded by CPEs must be performed on an annual basis and in a manner consistent with the instructions below.

- a) Using the CMS Form 2552-96 cost report for the fiscal year ending during the fiscal year data being used (ex. 2009 data for FFY 2011 DSH payments), an allowable routine per diem cost will be calculated for each SCDMH hospital for DSH

payment purposes. The state will determine each SCDMH hospital's DSH eligible routine per diem cost by first summing the inpatient hospital routine service cost centers. These amounts will be derived from worksheet B, Part I, column 25 (which includes GME cost, if applicable). Total inpatient hospital days and subprovider days (if applicable) will be obtained from Worksheet S-3, Part 1. Any subprovider cost identified as a non inpatient hospital cost (e.g. Psychiatric Residential Treatment Facility (PRTF)) will be excluded from the calculation of the inpatient hospital's routine cost. Next, in order to determine the DSH eligible inpatient hospital ancillary service costs associated with SC uninsured, Medicaid managed care enrollees, dual (Medicare/Medicaid) eligibles, and Medicaid eligibles who have inpatient hospital services reimbursed by a commercial insurance carrier, covered inpatient ancillary charges by ancillary cost center and payor class obtained from the annual SC Medicaid DSH Survey will be multiplied by the applicable "cost" cost to charge ratio(s) by ancillary cost center reflected on Worksheet C. Therefore, to determine each hospital's DSH eligible allowable inpatient hospital cost, the DSH eligible routine per diem cost will be multiplied by SC DSH eligible inpatient days to determine allowable DSH eligible inpatient hospital routine costs. The DSH eligible days will be obtained from the annual SC Medicaid DSH Survey. The DSH eligible allowable inpatient hospital routine cost will then be added to the DSH eligible allowable inpatient ancillary costs to determine total allowable DSH eligible inpatient hospital costs.

- b) The inpatient hospital cost associated with the South Carolina uninsured and Medicaid eligibles as described above will be trended using the CMS Market Basket Index as described in section VII. of Attachment 4.19-A. The trended cost will then be reduced by payments received from uninsured patients as well as payments received on behalf of inpatient hospital services provided to Medicaid eligibles as described above to determine each hospital's estimated maximum amount of uncompensated care costs to be reimbursed during the DSH payment period.
- c) The uncompensated care cost as described above will be used in the development of the interim DSH payment amount as described in section VII. of Attachment 4.19-A.
- d) Final Reconciliation of Interim Medicaid DSH Payments Post Reporting Year: Upon issuance of a Final Audit Report by the Agency's audit contractor beginning with the October 1, 2010 DSH Payment Program, the Agency will determine each SCDMH hospital's audited DSH eligible routine per diem cost by first summing the inpatient hospital routine service cost centers. These amounts will be derived from worksheet B, Part I, column 25 (which includes GME cost, if applicable). Total inpatient hospital days and subprovider days (if applicable) will be obtained from Worksheet S-3, Part 1. Any subprovider cost identified as a non inpatient hospital cost (e.g. Psychiatric Residential Treatment Facility (PRTF)) will be excluded from the calculation of the inpatient

hospital's routine cost. Next, in order to determine the DSH eligible inpatient hospital audited ancillary service costs associated with the uninsured and Medicaid eligibles (i.e. Medicaid managed care enrollees, dual (Medicare/Medicaid) eligibles, and Medicaid eligibles who have inpatient hospital services reimbursed by a commercial insurance carrier), covered inpatient ancillary charges by ancillary cost center by payor class will be multiplied by the applicable "cost" cost to charge ratio(s) by ancillary cost center reflected on Worksheet C. Therefore, to determine each hospital's audited DSH eligible inpatient hospital cost, the audited DSH eligible routine per diem cost will be multiplied by DSH eligible inpatient hospital days to determine audited DSH eligible inpatient hospital routine costs. The DSH eligible audited inpatient hospital routine cost will then be added to the DSH eligible audited inpatient ancillary costs to determine total audited DSH eligible inpatient hospital costs. The total audited DSH eligible inpatient hospital cost will then be reduced by payments received from uninsured patients as well as payments received on behalf of inpatient hospital services provided to Medicaid eligibles as described above to determine each hospital's audited hospital specific DSH limit for the DSH payment period. The redistribution of DSH payments that will take place beginning with the October 1, 2010 through September 30, 2011 DSH payment period will be described in section IX(C)(1)(b) of Attachment 4.19-A. However, SCDMH DSH hospitals cannot receive any more FFY 2010/2011 DSH payments than the maximum amount allowed under section VII(A)(1)(iv) of Attachment 4.19-A. In the event of a DSH underpayment, the Agency will reimburse the provider only the federal portion of the underpayment. In the event of a DSH overpayment, the Agency will recover only the federal portion of the overpayment.

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State Plan Under Title XIX of the Social Security Act

Medical Assistance Program

State: South Carolina

Citation

42 CFR 447, 434, 438, and 1902(a)(4), 1902(a)(6), and 1903

Payment Adjustment for Provider Preventable Conditions

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4), 1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

Health Care-Acquired Conditions

The State identifies the following Health Care-Acquired Conditions for non-payment under Section 4.19 (A)

X Hospital-Acquired Conditions as identified by Medicare other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients.

Effective July 11, 2011, Medicaid will make zero payments to providers for services related to Provider Preventable Conditions (PPC) which includes Healthcare Acquired Conditions (HCAC). Reimbursement for conditions described above is defined in Attachment 4.19-A, Page 26a of this State Plan

State Plan Under Title XIX of the Social Security Act

Medical Assistance Program

State: South Carolina

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Section(s) Attachment 4.19-A.

Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

Effective for discharges on or after July 1, 2014 the following OPPCs will not be reimbursed by the Medicaid Agency:

Post-operative death in normal healthy patient

Death/disability associated with use of contaminated drugs, devices or biologics

Death/Disability associated with use of device other than as intended

Death/disability associated to medication error

Maternal death/disability with low risk delivery

Death/disability associated with hypoglycemia

Death/disability associated with hyperbilirubinemia in neonates

Death/disability due to wrong oxygen or gas

Also consistent with the requirements of 42 CFR 447.26(c).

(c) (2) No reduction in payment for a provider preventable condition will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.

(c) (3) Reductions in provider payment may be limited to the extent that the following apply:

- i. The identified provider-preventable conditions would otherwise result in an increase in payment.
- ii. The State can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the provider-preventable conditions.

(c) (5) Non-payment of provider-preventable conditions shall not prevent access to services for Medicaid beneficiaries.

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