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

Financial Management Group

April 15, 2019

Joshua D. Baker, Director
Department of Health & Human Services
1801 Main Street
Columbia, SC 29201
RE: State Plan Amendment (SPA) 16-0014

Dear Mr. Baker:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number 16-0014. Effective October 1, 2016, this amendment proposes to update the DSH program including: (1) updates the base year used to calculate the interim DSH payments and update the inflation rate used to trend the DSH base year cost; (2) calculates the IP and OP hospital CCR specific to patient populations to determine the cost of DSH eligible cost pools; (3) eliminate the $8.7M DSH payment reduction criteria; (4) continue to apply a normalization adjustment to the hospital specific DSH limits; (5) create a separate DSH pool from the existing DSH allotment that will be spread among the SC defined rural hospitals to include hospitals in persistent poverty counties up to 100% of their DSH unreimbursed costs; (6) create a new Transformation pool for financially distressed hospitals; and (7) update the out of state border hospital DSH eligibility criteria.

In addition, SC will update the following IP hospital payments: (1) update the swing bed and administrative day rates; (2) update the long term per diem psychiatric hospital rates; (3) update the defined rural hospital criteria and modify the allowable retrospective cost settlement percentages for IP and OP hospital reimbursement.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a), and 1923 of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C. We have found that the proposed reimbursement methodology complies with applicable requirements and therefore have approved them with an effective date of October 1, 2016. We are enclosing the CMS-179 and the amended approved plan pages.

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

Sincerely,

Kristin Fan
Director

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 16-0014

2. STATE: South Carolina

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

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
October 1, 2016

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR Part 447 Subpart C

7. FEDERAL BUDGET IMPACT:
a. FFY 2017 $ $623,875
b. FFY 2018 $ $0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-A pages, 1, 2, 5, 9, 17, 22, 24, 26a, 26a.1, 26a.2, 26c, 26d, 26f, 26g, 27, 28, 28a, 28a.1, 29a (new page), 33

(4.19-A pages 28a.2, 28a.3 and 28a.4 will be removed from the Medicaid State Plan with the approval of this amendment due to deleted language)

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

Attachment 4.19-A pages, 1, 2, 5, 9, 17, 22, 24, 26a, 26a.1, 26a.2, 26c, 26d, 26f, 26g, 27, 28, 28a, 28a.1, 33

10. SUBJECT OF AMENDMENT:
FFY 2017 DSH Payment Methodology and Inpatient Hospital Payment Methodology.

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Mr. Soura was designated by the Governor to review and approve all State Plans

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Christian L. Soura

14. TITLE:
Director

15. DATE SUBMITTED:
December 21, 2016

16. RETURN TO:

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

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED:
APR 15 2019

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
OCT 01 2016

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: Kristin Fam

22. TITLE: Director, FMG

23. REMARKS:

FORM HCFA-179 (07-92)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF SOUTH CAROLINA

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

I. General Provisions

A. Purpose

This plan establishes:

1. a retrospective reimbursement system for qualifying South Carolina rural acute care hospitals and qualifying burn intensive care unit hospitals as defined in the plan;

2. a prospective reimbursement system for all other acute and non-acute care hospitals providing inpatient hospital services including all long-term psychiatric hospitals;

3. a prospective payment reimbursement system for private and governmental psychiatric residential treatment facilities.

It describes principles to be followed by Title XIX inpatient hospital and psychiatric residential treatment providers and presents the necessary procedures for setting rates, making adjustments, calculating retrospective cost settlements for qualifying acute care hospitals, auditing cost reports and managing the hospital disproportionate share (DSH) program.

B. Objectives

Effective October 1, 1997, the Balanced Budget Act (BBA) of 1997 repeals the OBRA 1981 requirement. In its place, the BBA of 1997 provides for a public process for determination of hospital payment rates. This public process will take place for all changes in payment for inpatient hospital and disproportionate share.

Inpatient hospital reimbursement shall be made in accordance with the upper payment limit requirements of Section 447.272.

C. Overview of Reimbursement Principles

1. The South Carolina Medicaid Program will reimburse qualified providers for inpatient institutional services using one or more of the following methods effective for discharges occurring on or after October 1, 2015:

a. Prospective payment rates will be reimbursed to contracting out-of-state acute care hospitals with SC Medicaid fee for service inpatient claim utilization of less than 200 SC Medicaid fee for service claims during its HFY 2011 cost reporting period via a statewide per discharge rate.

b. Prospective payment rates will be reimbursed to free standing short term psychiatric hospitals that contract with the SC Medicaid Program for the first time or reenter the SC Medicaid Program effective on or after July 1, 2014 via a statewide free standing short term psychiatric hospital statewide average rate (see page 16, section 1.e.).

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

d. Effective for discharges occurring on or after October 1, 2014, all SC general acute care hospitals except those designated as SC defined rural hospitals which include all SC Critical Access Hospitals (CAH); all SC hospitals located in the state's Zip Code Tabulation Areas (ZCTAs) classified as Moderately Rural/Rural; all SC hospitals located in Primary Care Health Professional Shortage Areas (HPSAs) for Total Population; SC hospitals located in Persistent Poverty Counties with ≤130 Licensed Beds; and SC hospitals located in Equally Rural/Urban ZCTAs with ≤90 Licensed Beds plus qualifying burn intensive care unit hospitals which contract with the SC Medicaid Program will receive prospective payment rates using a cost target established at 93%. However, the DME and IME cost component of these SC general acute care hospitals with intern/resident and allied health alliance programs will be allowed at eighty-seven. three percent (87.3%) of allowable SC Medicaid inpatient hospital DME (including the DME capital related costs) and IME costs during the rate setting process. Effective for discharges occurring on or after October 1, 2014, the base rate component of the July 1, 2014 per discharge rate of those hospitals impacted by the July 1, 2014 rate normalization action or the base rate component of the October 1, 2013 per discharge rate of those hospitals not impacted by the July 2014 rate normalization action of the SC general acute care hospitals other than the SC defined rural hospitals and qualifying burn intensive care unit hospitals will be increased by 2.50%.

e. Effective for discharges occurring on or after October 1, 2014, SC defined rural hospitals (see page 9) which include all SC Critical Access Hospitals (CAH); all SC hospitals located in the state's Zip Code Tabulation Areas (ZCTAs) classified as Moderately Rural/Rural; all SC hospitals located in Primary Care Health Professional

11. Cost Target - A hospital specific target developed for Medicaid inpatient hospital rate setting activities which uses hospital specific Medicaid inpatient hospital cost to charge ratios and Medicaid covered inpatient charges to develop the Medicaid inpatient cost target which is adjusted accordingly as the plan prescribes.

12. CRNA - Certified Registered Nurse Anesthetist.

13. Diagnosis Related Groups (DRGs) - A patient classification that reflects clinically cohesive groupings of patients who consume similar amounts of hospital resources.

14. 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.

15. 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.

16. 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) that received FFY 2016 SC Medicaid DSH payments 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%.

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

35. 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.

36. 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.

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

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

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

Effective for inpatient and outpatient hospital services provided on and after October 1, 2016, the SCDHHS will add the following criteria to the ''South Carolina Defined Rural Hospitals Criteria'':

- To include hospitals located in persistent poverty counties as defined in Public Law 112-74.

38. Special Care Unit - A unit as defined in 42 CFR 413.53 (d).

39. Standard Deviation - The square root of the sum of the squares of the deviation from the mean in a frequency distribution.

40. 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.

2. A. Per Diem Prospective Payment Rate - Long-Term Psychiatric Hospitals Effective November 1, 2013.

Only free-standing governmental long-term care psychiatric hospitals are included in this computation.

a) Total allowable Medicaid costs are determined for each governmental long term psychiatric hospital using its fiscal year 2012 Medicaid cost report. Allowable costs would include both routine and ancillary services covered by the long term psychiatric hospital.

b) Next, total patient days incurred by each hospital during its cost reporting period were obtained from each provider's Medicaid cost report.

c) Next, in order to determine the per diem cost for each governmental long term psychiatric hospital, total allowable Medicaid reimbursable costs for each provider is divided by the number of patient days incurred by the provider to arrive at its per diem cost.

d) Finally, in order to trend the governmental long term psychiatric hospitals base year per diem cost (i.e. July 1, 2011 through June 30, 2012 to the payment period (i.e. November 1, 2013 through September 30, 2014), the agency employed the use of the applicable CMS Market Basket Rates for Inpatient Psychiatric Facilities to determine the trend rate of 5.37%:

RY 2013- 2.7%
RY 2014- 2.6%

e) Effective July 1, 2016, the non-state owned governmental long-term care psychiatric hospital rate was updated based upon its fiscal year end 2015 cost report and trended to the annual payment period using the FY 2016 CMS Market Basket Trend Rate for Inpatient Psychiatric Facilities of 2.4%. Effective October 1, 2016, the state owned governmental long-term care psychiatric hospital rates were updated based upon its fiscal year end 2015 cost report and trended to the annual payment period using the midpoint to midpoint methodology and the use of the 4th Quarter Global Insight Indexes - 2010 Based CMS Inpatient Psychiatric Facilities.

f) For private long term psychiatric hospitals that do not receive a hospital specific per diem rate, a statewide per diem rate will be developed by first multiplying the governmental long term psychiatric hospitals per diem rate by the Medicaid patient days incurred during its base year cost reporting period. Next, the sum of the Medicaid allowable cost amounts for all governmental long term psychiatric hospitals was divided by the sum of the incurred Medicaid patient days to determine the statewide per diem rate for private long term psychiatric hospitals effective November 1, 2013. The hospital will be reimbursed based upon the lesser of its calculated per diem based upon actual costs or the statewide rate.

g) Effective for services provided on or after December 1, 2015 and in the event that two or more state owned governmental long term psychiatric hospitals consolidate and operate under one license as one entity, the surviving hospital will be allowed to receive a rate based upon a budgeted cost report beginning with the effective date of such consolidation. The surviving hospital will be allowed to receive retrospective cost settlements at 100% of allowable Medicaid reimbursable costs through September 30, 2017. A future plan amendment will be developed to describe the prospective rate setting process for this hospital with an effective date of October 1, 2017 at a later date.

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

E. Payment for Swing Bed Days

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

November 1, 2011 -September 30, 2012	150.53
October 1, 2012 -September 30, 2013	155.88
October 1, 2013 - September 30, 2014	162.19
October 1, 2014 - September 30, 2015	167.68
October 1, 2015 - September 30, 2016	168.65
October 1, 2016	171.04

This rate calculation is described in the Nursing Home State Plan Attachment 4.19-D.

F. Payment for Administrative Days

Acute care facilities will be reimbursed for Medicaid eligible skilled or intermediate patients who no longer require acute care and are waiting for nursing home placement. Administrative days must follow an acute inpatient hospital stay and will be covered in any hospital as long as a nursing home bed is not available. Reimbursement for administrative days is described below.

1. Each administrative day will be paid in accordance with the rate schedule shown below. This daily rate will be considered payment in full. There will be no cost settlement. This rate is a combination of the swing bed rate, as defined above, plus the Pharmacy per diem used for nursing facility UPL payments:

November 1, 2011 -September 30, 2012	159.42 (ARM 8.89)
October 1, 2012 September 30, 2013	164.77 (ARM 8.89)
October 1, 2013 September 30, 2014	171.08 (ARM 8.89)
October 1, 2014 - September 30, 2015	180.76 (Pharmacy Per Diem 13.08)
October 1, 2015 - September 30, 2016	183.85 (RX Per Diem 15.20)
October 1, 2016 -	187.97 (RX Per Diem 16.93)

2. Patients who require more complex care services will be reimbursed using rates from the following schedule.

October 1, 2003 - September 30, 2004	188.00
October 1, 2004 - September 30, 2005	197.00
October 1, 2005 - September 30, 2006	206.00
October 1, 2006 - September 30, 2007	215.00
October 1, 2007 - November 30, 2008	225.00
December 1, 2008 - April 7, 2011	364.00
April 8, 2011. -. September 30, 2011	353.08
October 1, 2011 -	450.00

This rate calculation is described in the Nursing Home State Plan Attachment 4.19-D., Section III I.

- Effective for discharges occurring on or after October 1, 2014, SC general acute care hospitals which are designated as SC defined rural hospitals will receive retrospective cost settlements that represent one-hundred percent (100%) of allowable SC Medicaid inpatient costs which includes base, capital, DME and IME costs, subject to the exceptions provided in the July 1, 2014 inpatient hospital normalization action.

- Effective for discharges occurring on or after October 1, 2013, the retrospective cost settlement amount for qualifying hospitals with a burn intensive care unit will be limited to one-hundred percent (100%) of allowable SC Medicaid inpatient costs which includes base, capital, DME and IME costs, subject to the exceptions provided in the July 1, 2014 inpatient hospital normalization action.

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

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

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

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

  (2) Hospitals designated as a SC defined rural hospital for the first time on and after October 1, 2014 will receive the greater of interim Medicaid fee for service reimbursement or 90% of allowable Medicaid reimbursable inpatient hospital costs, but not to exceed 100% of allowable Medicaid reimbursable costs (Cannon, McLeod Loris, and Union);

  (3) Hospitals designated as a SC defined rural hospital for the first time on and after October 1, 2016 will receive the greater of interim Medicaid fee for service reimbursement or 80% of allowable Medicaid reimbursable inpatient hospital costs, but not to exceed 100% of allowable Medicaid reimbursable costs (The Regional Medical Center).

N. Upper Payment Limit Calculation

I. Non-State Owned Governmental and Private Inpatient Hospital Service Providers

The following methodology is used to estimate the upper payment limit applicable to non-state owned governmental and privately owned or operated inpatient hospitals (i.e. for profit and non-governmental nonprofit facilities):

The most recent HFY 2015 2552-10 cost report serves as the base year cost report to be used for Medicaid UPL calculations. In order to determine the Medicare allowable cost using Medicare allowable cost principles (i.e. upper payment limit), the SCDHHS employs the following process:

(1) Covered Medicaid inpatient hospital routine charges are determined by multiplying covered Medicaid inpatient hospital routine billed charges by the ratio of Medicaid Covered days to Medicaid billed days. Data source – Summary MARS inpatient hospital report.

(2) Covered Medicaid inpatient hospital ancillary charges are determined by multiplying covered Medicaid inpatient hospital ancillary billed charges by the ratio of Medicaid Covered days to Medicaid billed days. Data source – Summary MARS inpatient hospital report.

(3) Medicaid covered inpatient hospital routine cost is determined by multiplying Medicaid routine days as identified on worksheet S-3, column 7, lines 1, 8 thru 13 and 16 thru 17 by the routine cost per diems determined by the amounts reflected on worksheet B Part I, column 24, lines 30 thru 40 divided by total days of each routine cost center reflected on worksheet S-3, column 8, lines 1 thru 18. Data source – HFY 2552-10 cost report.

(4) Medicaid covered inpatient hospital ancillary cost is determined by multiplying covered Medicaid inpatient hospital ancillary charges as identified on worksheet D-3, column 2, lines 50 thru 117 by the ancillary cost to charge ratios as reflected on worksheet C, column 8, lines 50 thru 117. Data source – HFY 2552-10 cost report.

(5) Total Medicaid inpatient hospital cost for federal fiscal year 2015 is determined by combining Medicaid covered inpatient hospital routine cost (step 3) with covered Medicaid inpatient hospital ancillary cost (step 4). The total Medicaid inpatient hospital cost is then trended using the mid-year to mid-year inflation method and the Fourth Quarter 2015 Global Insight Indexes of 2010 Based CMS Hospital PPS Market Basket in order to trend the base year cost (HFY 2014) to the Medicaid rate period October 1, 2016 through September 30, 2017.

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

(7) Next, to account for the changes in the Medicaid payment/rate updates effective October 1, 2013, July 1, 2014, October 1, 2014, and the impact of the October 1, 2015 normalization action on the October 1, 2014 per discharge rates, the annual Medicaid revenue in step (6) was multiplied by the applicable portion of the hospital specific increases/(decreases) associated with the actions listed above to determine the projected Medicaid revenue for the period October 1, 2016 through September 30, 2017. For hospitals that continue to receive retrospective cost settlements at 100% of allowable costs on and after October 1, 2016, the estimated revenue for the October 1, 2016 through September 30, 2017 payment period equals the trended inflated cost as described in step (5) subject to the impact of the July 1, 2014 and October 1, 2015 rate normalization actions.

(8) The Medicaid UPL compliance check is determined for each class by comparing the aggregate amounts as determined in (5) above to ensure that projected Medicaid inpatient hospital cost is equal to or greater than projected Medicaid inpatient hospital rate expenditures in step (7). In the event that aggregate Medicaid inpatient hospital rate expenditures exceed aggregate Medicaid hospital cost, the Medicaid per discharge rate for each facility will be limited to the Medicaid cost based rate as determined in (5) above

II. State Owned Governmental Psychiatric Hospital Services

The following methodology is used to estimate the upper payment limit applicable to state owned governmental inpatient psychiatric hospitals:

The most recent HFY 2015 2552-10 cost report serves as the base year cost report to be used for Medicaid rate setting and UPL calculations. In order to determine the Medicare allowable cost using Medicare allowable cost principles (i.e. upper payment limit), the SCDHHS employs the following process:

(1) Medicaid covered inpatient hospital routine cost is determined by multiplying Medicaid routine days as identified on worksheet S-3, column 7, lines 1 and 8 thru 13 by the routine cost per diems determined by the amounts reflected on worksheet B Part I, column 24, lines 30 thru 40 divided by total days of each routine cost center reflected on worksheet S-3, column 8, lines 1 thru 13. Data source - HFY 2552-10 cost report.

(2) Medicaid covered inpatient hospital ancillary cost is determined by multiplying Medicaid routine days as identified on worksheet S-3, column 7, lines 1 and 8 thru 13 by the sum of the ancillary cost centers determined by the amounts reflected on worksheet B Part I, column 24, lines 50 thru 117 divided by total days of all routine cost centers reflected on worksheet S-3, column 8, lines 1 thru 13. Data source - HFY 2552-10 cost report.

(3) Total Medicaid inpatient hospital cost is determined by combining Medicaid covered inpatient hospital routine cost (step 1) with covered Medicaid inpatient hospital ancillary cost (step 2). The total Medicaid inpatient hospital cost is then trended using the mid-year to mid-year inflation method and the Fourth Quarter 2015 Global Insight Indexes of 2010 Based CMS Hospital PPS Market Basket in order to trend the base year cost (HFY 2015) to the Medicaid rate period October 1, 2016 through September 30, 2017.

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

(5) Total projected Medicaid inpatient hospital revenue is determined by taking the July 1, 2016 or October 1, 2016 Medicaid per diem rate multiplied by the HFY 2015 Medicaid days as identified via the DataProbe report.

(6) The Medicaid UPL compliance check is determined for this class by comparing the aggregate amounts as determined in (3) above to ensure that projected Medicaid inpatient hospital cost is equal to or greater than projected Medicaid inpatient hospital rate expenditures in step 5. In the event that aggregate Medicaid inpatient hospital rate expenditures exceed aggregate Medicaid hospital cost, the Medicaid per discharge rate for each facility will be limited to the Medicaid cost based rate as determined in (3) above.

2. Reimbursement Methodology. Each qualifying hospital shall receive quarterly supplemental enhanced payments for the inpatient services rendered during the quarter. In addition to the limitations resulting from the application of the upper payment limit for hospitals reflected in 42 C.F.R. 447.272(a)-(b), annual supplemental enhanced payments to each qualifying hospital as described below, in any Medicaid State Plan rate year shall be limited to the lesser of:

   a. the difference between the hospital's Medicaid inpatient covered charges and Medicaid payments the hospital receives for services processed for fee-for-service Medicaid recipients during the Medicaid State Plan rate year, including any Medicaid inpatient cost settlement the hospital receives for the Medicaid State Plan rate year under Section VI(I) of the state plan; or

   b. for hospitals participating in the Medicaid Disproportionate Share Hospital (DSH) Program, the difference between the hospital's hospital specific DSH limit, as defined in Section VII of the state plan, and the hospital's DSH payments during the Medicaid State Plan rate year.

   c. In the event the payment limitations described in subsections a. or b. exceed the aggr egate 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 hospital s.

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 2015 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, 2016, base year cost will be trended accordingly using CMS Market Basket rates. For payments made on and after October 1, 2016, base year cost will be trended using the midpoint to midpoint methodology and the use of the Global Insight 2010 Based CMS Hospital Prospective Reimbursement Quarterly Market Basket Indexes (4th Qtr. 2015 Edition). Medicaid base year revenue will be adjusted accordingly to reflect changes made to SC Medicaid inpatient hospital reimbursement during the October 1, 2013, July 1, 2014, October 1, 2014, and October 1, 2015 rate/normalization actions up through September 30, 2017. For subsequent fiscal years, data utilized from the HFY 2552-10 cost report and HFY Summary MARS Report will be no older than 2 years prior to the projected spending year.

county based on the hospital's Core Based Statistical Area in the Centers for Medicare and Medicaid May 2013 Public Use File.

2. Reimbursement Methodology. Each qualifying hospital shall receive quarterly supplemental enhanced payments for the inpatient services rendered during the quarter. In addition to the limitation s 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 hos pital'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 limit ations 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 2015 2552-10 cost report serves as the base year cost report used to establish the maximum supplemental enhanced payments. In order to determi ne 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, 2016, base year cost will be trended accordingly using CMS Market Basket rates. For payments made on and after October 1, 2016, base year cost will be trended using the midpoint to midpoint methodology and the use of the Global Insight 2010 Based CMS Hospital Prospective Reimbursement Quarterly Market Basket Indexes (4th Qtr. 2015 Edition). Medicaid base year revenue will be adjusted accordingly during the October 1, 2013, July 1, 2014, October 1, 2014, and October 1, 2015 rate/normalization actions up through September 30, 2017 to reflect changes made to SC Medicaid inpatient hospital reimbursement since October 1, 2014. For subsequent fiscal years, data utilized from the HFY 2552-10 cost report and HFY Summary MARS Report will be no older than 2 years prior to the projected spending year.

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 2017, qualification data will be based upon each hospital's fiscal year 2015 cost reporting period.

1. Effective for the October 1, 2016 - September 30, 2017 DSH payment period, the interim hospital specific DSH limit will be set as follows:

a. The interim hospital specific DSH limit for most SC general acute care hospitals that contract with the SC Medicaid Program will be equal to one hundred percent (100%) of the unreimbursed hospital cost for all (i.e. SC and out-of-state) uninsured patients, all Medicaid fee for service patients, all Medicaid managed care patients (including PACE Program participants), SC dual (Medicare/Medicaid) eligible patients, and all Medicaid patients who have inpatient and outpatient hospital services reimbursed by a commercial carrier. The hospital specific DSH limit for the SC general acute care hospitals that became rural for the first time under the SC defined Rural Hospital criteria will be equal to 90% for a hospital deemed rural for the first time effective October 1, 2014 and 80% for a hospital deemed rural for the first time effective October 1, 2016. The hospital specific DSH limit of the SC non-general acute care hospitals will equal to sixty percent (60%). The hospital specific DSH limit for all general acute care border hospitals (in North Carolina and Georgia) contracting with the SC Medicaid Program will be equal to sixty percent (60%) of the unreimbursed hospital cost for SC uninsured patients, SC Medicaid fee for service patients, SC Medicaid managed care patients (including PACE Program participants), SC dual (Medicare/Medicaid) eligible patients, and SC Medicaid patients who have inpatient and outpatient hospital services reimbursed by a commercial carrier. The December 19, 2008 Final Rule (as well as instructions/guidance provided by the DSH audit contractor) relating to the audits of the Medicaid DSH plans as well as the December 3, 2014 Final Rule relating to the Uninsured Definition will be the guiding documents that hospitals must use in providing the DSH data. When calculating the hospital specific DSH limit for both the SC general acute care hospitals as well as the out of state border hospitals and the SC non-general acute care hospitals which qualify for the SC Medicaid DSH Program effective for the FFY 2017 DSH payment period, the Medicaid Agency will adjust the limit of the impacted hospitals for the impacts relating to the October 1, 2015 Medicaid fee for service inpatient hospital per discharge rate and outpatient hospital multiplier normalization action.

Except for the SC Department of Mental Health (SCDMH) hospitals, for FFY 2017, 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 2015 cost reporting period charges for each group

listed above and multiplying that by the hospital's applicable FY 2015 unadjusted inpatient and outpatient hospital cost to charge ratios (i.e. Uninsured, Medicaid MCO, Medicaid FFS, and Medicare (Dual Eligibles)) to determine the base year cost for this group. In order to inflate each hospital's base year cost determined for each group identified above, each hospital's cost will be inflated from the base year to December 31, 2015 using the applicable CMS Market Basket Index described in (A)(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 all uninsured patients, all Medicaid fee for service, all dual eligibles, all Medicaid eligibles who have inpatient and outpatient hospital services reimbursed by a commercial carrier, and all Medicaid managed care patients to determine the total unreimbursed cost for each DSH hospital. Out of state border DSH qualifying hospitals and SC non-general acute care DSH qualifying hospitals will only report revenue received from SC residents. However, because of the Medicaid fee for service rate normalization action effective October 1, 2015, HFY 2015 Medicaid Managed Care payments and Medicaid fee for service payments will be increased/(decreased) appropriately for each impacted hospital. Additionally, to adjust for the hospital specific rate and outpatient multiplier normalization action effective October 1, 2015 that impacted certain hospitals, the Medicaid Agency will adjust the following DSH eligible unreimbursed cost pools as follows:

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

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

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

and October 1, 2015 percentage rate/multiplier changes. However please note that in order to account for the utilization of services that occur in the outpatient hospital setting (i.e. the use of outpatient hospital clinic services and emergency room services (available only if provided in a SC Level I Trauma Center hospital) versus all other ancillary services provided in an outpatient hospital setting), the Medicaid Agency will adjust the outpatient hospital normalization percentage adjustment downward based upon the ratio of SC Medicaid fee for service outpatient hospital clinic costs (and ER costs if applicable) to total SC Medicaid fee for service outpatient hospital ancillary service costs (including clinics) of those impacted hospitals.

ii) For FFY 2017, each SCDMH hospital's interim hospital specific DSH limit will be calculated using FYE June 30, 2015 cost report data for all of its Medicaid fee for service, uninsured, all dual (Medicare/Medicaid) eligible, and all Medicaid eligibles who have inpatient hospital services reimbursed by a commercial carrier. Each hospital's total allowable cost will be inflated from the base year to December 31, 2015 using the CMS Market Basket Index described in (A)(4) of this section. The inflated cost will be divided by total FYE June 30, 2015 acute care hospital days to determine a cost per day amount. This cost per day amount will be multiplied by the FYE June 30, 2015 acute care hospital days associated with all Medicaid fee for service, uninsured, all dual eligible, and all Medicaid eligibles who have inpatient hospital services reimbursed by a commercial carrier to determine the total amount of cost eligible under the hospital specific DSH limit. The inflated cost of each hospital determined above will be reduced by payments received from or for all Medicaid fee for service, uninsured patients, all dual eligibles, and all Medicaid eligibles who have inpatient and outpatient hospital services reimbursed by a commercial carrier to determine the total unreimbursed cost of each DSH hospital. In the event that any of the SCDMH hospitals provided inpatient hospital services for Medicaid managed care patients during FYE June 30, 2015, the previous methodology outlined above will be used to determine the unreimbursed Medicaid managed care cost to be added to the unreimbursed Medicaid eligible and uninsured cost previously described.

iii) For new S. C. general acute care hospitals which enter the SC Medicaid Program during the October 1, 2016 - September 30, 2017 DSH Payment Period, their interim hospital specific DSH limits 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, 2016 through September 30, 2017 Medicaid State Plan rate year.

iv) For the FFY 2016/2017 DSH payment period, proviso 33.21 (C) of the July 1, 2016 through June 30, 2017 South Carolina State Appropriations Act provides that SC Medicaid-designated rural hospitals in South Carolina shall be eligible to receive up to one hundred percent of costs associated with uncompensated care as part of the DSH program. To be eligible, rural hospitals must participate in reporting and quality guidelines published by the department and outlined in the Healthy Outcomes Initiative. Funds shall be allocated from the existing DSH program. Therefore based upon this proviso language, the Medicaid Agency will reimburse the following SC defined rural hospitals at the following percentages of their hospital specific DSH limit for FFY 2017:

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

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

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

v) In accordance with Budget Proviso 33.27(B) of the SFY 2016/2017 South Carolina State Appropriations Act, the agency will create a separate $20 million (total computable dollar) Transformation Pool from the existing FFY 2017 DSH allotment. Targeted hospitals will include those hospitals originally targeted in the FFY 2015 DSH Transformation Pool Project. Therefore, the total DSH allotment amount that will be spent in accordance with the DSH payment methodology previously described will equal $12,900,000.

- The Transformation hospital must be a DSH-eligible hospital in accordance with Attachment 4.19-A of the SC Medicaid State Plan;
- The following payment amounts were paid to the following Transformation Hospitals: CHS-Florence ($1,500,000); Providence Hospital ($3,800,000); The Regional Medical Center ($3,600,000) and; Self Regional ($4,000,000).
- Any transformation payments made from the FFY 2017 Transformation Pool must be applied against the Medicaid State Plan Rate Year 2017 DSH audit regardless of when they are paid (i.e. during FFY 2017 or FFY 2018)
- A Transformation pool hospital may not be reimbursed more than its hospital specific DSH limit when Transformation Pool payments made under this section are added to the base DSH payments as determined in Attachment 4.19A.
- Any remaining funds left over from the $20 million Transformation Pool will be dispersed.

VI. Effective for the FFY 2017 DSH payment period, the SCDHHS will create four separate DSH pools for the calculation of the interim DSH payments effective October 1, 2016. The first DSH pool will represent the $20 million Transformation Pool. The second DSH pool will represent the unreimbursed costs of the uninsured and Medicaid eligible recipients receiving inpatient psychiatric hospital services provided by South Carolina Department of Mental Health (SCDMH) hospitals. Under this pool, the SCDMH hospitals will receive (in the aggregate) up to one hundred percent of their specific DSH limit but not to exceed $60,903,051. Next, a third DSH pool will be created for SC defined rural hospitals from the existing FFY 2017 DSH allotment for the SC defined rural hospitals as described in iv. Above ($71,088,246). Finally, the remaining DSH allotment amount beginning October 1, 2016 may be available to all remaining DSH eligible hospitals ($351,690,681). In the event that the sum of the hospital specific DSH limits of the DSH qualifying hospitals exceeds the sum of DSH payment pool #4 beginning October 1, 2016, the hospital specific DSH limits will be decreased proportionately to ensure the hospital specific DSH limits are within the DSH payment pool #4 amount.

2. The October 1, 2016 - September 30, 2017 annual aggregate DSH payment amounts will not exceed the October 1, 2016 - September 30, 2017 annual DSH allotment amount and may not equal the annual DSH allotment amount.

3. The following CMS Market Basket index will be applied to hospitals' base year cost. FY 2015 2.9%

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

5. Effective October 1, 2010, all interim DSH payments will become final upon audit of the applicable Medicaid State Plan Rate Year. See section IX (C) (1) (b) for additional information.

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

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

- Hospitals designated as a SC defined rural hospital for the first time on and after October 1, 2014 will receive the greater of interim Medicaid fee for service reimbursement or 90% of allowable Medicaid reimbursable inpatient hospital costs, but not to exceed 100% of allowable Medicaid reimbursable costs (Cannon, McLeod Loris, and Union);

- Hospitals designated as a SC defined rural hospital for the first time on and after October 1, 2016 will receive the greater of interim Medicaid fee for service reimbursement or 80% of allowable Medicaid reimbursable inpatient hospital costs, but not to exceed 100% of allowable Medicaid reimbursable costs (The Regional Medical Center).

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

I. Hospital Cost Reports

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

a. Supplemental worksheets submitted by hospitals for the disproportionate share program will be reviewed for accuracy and reasonableness by DHHS. Beginning with the 2005 DSH period, the DSH program will undergo an audit by an independent auditor. The findings from these audits could result in educational intervention to ensure accurate reporting.

b. As required by Section 1923(j) of the Social Security Act related to auditing and reporting of Disproportionate Share Hospital (DSH) payments, the Medicaid Agency will implement procedures to comply with the DSH hospital payments final rule issued in the December 19, 2008, Federal Register, with effective date of January 19, 2009, to ensure that the hospital specific DSH limits have not been exceeded. The redistribution methodology described below effective for the DSH payment periods beginning on and after October 1, 2011 will ensure that the final DSH payments received by each DSH hospital will not exceed its hospital specific DSH limit determined for the Medicaid State Plan Rate Year being audited.

- First, SCDHHS will create three separate DSH pools. (1) – SC state owned governmental long term psych hospitals; (2) out of state border DSH qualifying hospitals; and (3) – SC qualifying DSH Hospitals.

- Next, the SCDHHS will redistribute the interim DSH payments made to the hospitals contained within DSH pools (1) and (3) based upon the audited hospital specific DSH limits contained within the DSH audit report and adjusted to reflect the impact of the July 1, 2014 and October 1, 2015 SC Medicaid fee for service inpatient and outpatient hospital rate/multiplier normalization actions for the Medicaid State Plan Rate Year being audited. The final DSH payment amounts for hospitals contained within DSH pools (1) and (3) will be calculated in accordance with the methodology and pools contained within Section VII(a) (1) (a) (iv) ,(v), and (vi) of Attachment 4.19-A, less any DSH payments made to hospitals contained within DSH pool (2). The DSH payments for hospitals contained within DSH pool (2) will be considered settled as paid.