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

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

Financial Management Group

February 24, 2020

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

RE: State Plan Amendment (SPA) 19-0013

Dear Mr. Baker:

We have reviewed the proposed amendment to Attachment 4.19-A/B of your Medicaid State plan submitted under transmittal number 19-0013. Effective January 1, 2020, SC proposes to update their DSH program as well as inpatient hospital payments. Specifically, this SPA: (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) expend 100% of its FFY 2020 allotment; (3) discontinue the normalization adjustment to the hospital specific DSH limits; (4) update the inflation rate used to trend the DSH base year cost to the end of the 2018 calendar year; and (5) create a separate DSH pool from the existing 2020 DSH allotment to be spread among rural hospitals.

Also effective January 1, 2020, SC will: (1) update the swing bed and administrative day rates based on the updated October 1, 2019 NF rates; (2) update the long term per diem psychiatric hospital rates based on the FY June 30, 2018 cost reporting period trended forward to the payment period; and (3) provide for 100% retrospective cost settlement for all IP and OP services in rural hospitals.

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 January 1, 2020. 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: 19-0013

2. STATE: South Carolina

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

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

4. PROPOSED EFFECTIVE DATE
January 1, 2020

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 2020 $9.186 million
b. FFY 2021 $9.304 million

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-A, pages 17, 22, 24, 26a, 26a.1, 26a.2, 26c, 26d, 26f, 26g, 27, 28, 28a, 29a
(Due to Language Deletion/shifts page 28a.1 is being removed from the SC State Plan)
Attachment 4.19-B, pages 1a.7, 1a.8, 1a.9

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-A, pages 17, 22, 24, 26a, 26a.1, 26a.2, 26c, 26d, 26f, 26g, 27, 28, 28a, 29a

Attachment 4.19-B, pages 1a.7, 1a.8, 1a.9

10. SUBJECT OF AMENDMENT: This plan amendment is for the SC DSH payment program and updates effective for Federal Fiscal year (FFY) 2020, October 1, 2019 through September 30, 2020, DSH payment period. The inpatient hospital swing bed rate and administrative day rate update effective January 1, 2020. The SC Department of Mental Health hospital rate update effective January 1, 2020. Effective January 1, 2020 all SC defined rural hospitals will receive retrospective cost settlements at 100% of allowable costs for IP and OP services. Effective FFY 2020, all SC defined rural hospitals will receive 100% of its hospital specific DSH limit. This SPA does not include the DSH ACA reductions

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

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Joshua D. Baker

14. TITLE:
Director

15. DATE SUBMITTED:
December 30, 2019

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: February 24, 2020

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
January 1, 2020

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Kristin Fan

22. TITLE:
Director, FMG

23. REMARKS:

FORM HCFA-179 (07-92)

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, 2017, 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 payment period using the midpoint to midpoint methodology and the use of the 1st Quarter 2017 Global Insight Indexes - 2012 Based CMS Inpatient Psychiatric Facilities.

f) Effective January 1, 2020, the state owned governmental long-term care psychiatric hospital rates were updated based upon its fiscal year end 2018 cost report and trended to the payment period using the midpoint to midpoint methodology and the use of the 2nd Quarter 2019 Global Insight Indexes - 2016 Based Inpatient Psychiatric Facilities.

g) 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.

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

E. Payment for Swing Bed Days

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

October 1, 2013 - September 30, 2014	162.19
October 1, 2014 - September 30, 2015	167.68
October 1, 2015 - September 30, 2016	168.65
October 1, 2016 - September 30, 2017	171.04
October 1, 2017 - December 31, 2018	176.70
January 1, 2019 - December 31, 2019	181.87
January 1, 2020 -	192.04

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:

October 1, 2013 September 30, 2014	171.08 (ARM 8.89)
October 1, 2014 - September 30, 2015	180.76 (Pharmacy Per Diem 13.08)
October 1, 2015 - September 30, 2016	183.85 (RX Per Diem 15.20)
October 1, 2016 - September 30, 2017	187.97 (RX Per Diem 16.93)
October 1, 2017 - December 31, 2018	195.27 (RX Per Diem 18.57)
January 1, 2019 - December 31,2019	202.21 (RX Per Diem 20.34)
January 1, 2020	211.96 (RX Per Diem 19.92)

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 de fined 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 hospit al 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, Fairf ield, GHS Laurens, Hampton, Lake City, M cLeod 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).

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

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 2018 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 2018 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 Second Quarter 2019 Global Insight Indexes of 2014 Based CMS Hospital PPS Market Basket in order to trend the base year cost (HFY 2018) to the Medicaid rate period October 1, 2019 through September 30, 2020.

(6) Total Medicaid inpatient hospital revenue is derived from each hospital's Summary MARS report and will be adjusted accordingly to reflect any rate/methodology changes that may have been implemented between the base year and UPL demonstration period.

(7) Next, For hospitals that continue to receive retrospective cost settlements at 100%, 90%, or 80% of allowable costs on and after October 1, 2019, the estimated revenue for the October 1, 2019 through September 30, 2020 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 2018 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 Second Quarter 2019 Global Insight Indexes of 2014 Based CMS Hospital PPS Market Basket in order to trend the base year cost (HFY 2018) to the Medicaid rate period October 1, 2019 through September 30, 2020.

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

(5) Total projected Medicaid inpatient hospital revenue is determined by taking the October 1, 2018 and January 1, 2020 Medicaid per diem rates multiplied by the HFY 2018 Medicaid days as identified via the DataProbe report.

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

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

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

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

   c. In the event the payment limitations described in subsections a. or b. exceed the aggregate annual upper payment limit for non-state government operated hospitals, each qualifying hospital's payment will be proportionately reduced to maintain compliance with the aggregate annual upper payment limit for non-state government operated hospitals.

3. UPL Calculation for Supplemental Enhanced Payment

   The following methodology is used to determine the maximum supplemental enhanced payments for qualifying non-state owned governmental and privately owned or operated inpatient hospitals (i.e. for profit and non-governmental nonprofit facilities).

   The most recent HFY 2018 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, 2019, base year cost will be trended accordingly using CMS Market Basket rates. For payments made on and after October 1, 2019, base year cost will be trended using the midpoint to midpoint methodology and the use of the Global Insight 2014 Based CMS Hospital Prospective Reimbursement Quarterly Market Basket Indexes (2nd Qtr. 2019 Edition). Medicaid base year revenue will be adjusted accordingly, if applicable, to reflect changes made to SC Medicaid inpatient hospital reimbursement. For subsequent fiscal years, data utilized from the HFY 2552-10 cost report and HFY Summary MARS Report will be no older than 2 years prior to the projected spending year.

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 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 2018 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, 2019, base year cost will be trended accordingly using CMS Market Basket rates. For payments made on and after October 1, 2019, base year cost will be trended using the midpoint to midpoint methodology and the use of the Global Insight 2014 Based CMS Hospital Prospective Reimbursement Quarterly Market Basket Indexes (2nd Qtr. 2019 Edition). Medicaid base year revenue will be adjusted accordingly, if applicable, to reflect changes made to SC Medicaid inpatient hospital reimbursement. For subsequent fiscal years, data utilized from the HFY 2552-10 cost report and HFY Summary MARS Report will be no older than 2 years prior to the projected spending year.

VII. Disproportionate Share

A. Payments

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

1. Effective for the October 1, 2019 - September 30, 2020 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 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.

Except for the SC Department of Mental Health (SCDMH) hospitals, for FFY 2020, 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 2018 cost reporting period charges for each group listed above and multiplying that by the hospital's applicable FY 2018 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, 2018 using the applicable CMS Market Basket Index described in (A)(3) of this section. The inflated cost of each hospital for each group determined above will be summed and reduced by payments received from or for all uninsured patients, all Medicaid fee for service, all dual eligibles, all Medicaid eligibles who have inpatient and outpatient hospital services reimbursed by a commercial carrier, and all Medicaid managed care patients to determine the total unreimbursed cost for each DSH hospital. HFY 2018 base revenue for Medicaid fee for service and Medicaid managed care enrollees will be adjusted to account for any Medicaid fee for service reimbursement actions implemented during or after the base year. Out of state border DSH qualifying hospitals will only report charges and revenue received from SC residents.

ii) For FFY 2020, each SCDMH hospital's interim hospital specific DSH limit will be calculated using FYE June 30, 2018 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, 2018 using the CMS Market Basket Index described in (A)(3) of this section. The inflated cost will be divided by total FYE June 30, 2018 acute care hospital days to determine a cost per day amount. This cost per day amount will be multiplied by the FYE June 30, 2018 acute care hospital days associated with all Medicaid fee for service, uninsured, all dual eligible, and all Medicaid eligibles who have inpatient hospital services reimbursed by a commercial carrier to determine the total amount of cost eligible under the hospital specific DSH limit. The inflated cost of each hospital determined above will be reduced by payments received from or for all Medicaid fee for service, uninsured patients, all dual eligibles, and all Medicaid eligibles who have inpatient and outpatient hospital services reimbursed by a commercial carrier to determine the total unreimbursed cost of each DSH hospital. Medicaid fee for service revenue will be adjusted to account for any Medicaid rate increase provided since the base year. In the event that any of the SCDMH hospitals provided inpatient hospital services for Medicaid managed care patients during FYE June 30, 2018, the previous methodology outlined above will be used to de termine 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, 2019 - September 30, 2020 DSH Payment Period, their interim hospital specific DSH limits will be based upon projected DSH qualification, cost, charge and payment data that could be subject to further revision based upon the audited DSH qualification, cost, charge and payment data resulting fro m the audit of the October 1, 201 9 through September 30, 20 20 Medicaid State Plan rate year.

iv) For the FFY 2019/2020 DSH payment period, SC Medicaid-designated rural hospitals in South Carolina shall be eligible to receive up to one hundred percent of costs associated with uncompensated care as part of the DSH program. Funds shall be allocated from the existing DSH program. To be eligible, rural hospitals must participate in reporting and quality guidelines published by the department and outlined in the Healthy Outcomes In itiative.

v) Effective for the FFY 2020 DSH payment period, the SCDHHS will create three separate DSH pools for the calculation of the interim DSH payments effective October 1, 2019. The first DSH pool will represent the unreimbursed costs of the uninsured and Medicaid eligible recipients receiving inpatient psychiatric hospital services provided by South Carolina Department of Mental Health (SCDMH) hospitals. Under this pool, the SCDMH hospitals will receive (in the aggregate) up to one hundred percent of their specific DSH limit but not to exceed $60,903,051. Next, a second DSH pool will be created for SC defined rural hospitals from the existing FFY 2020 DSH allotment for the SC defined rural hospitals as described in iv. above. Finally, the remaining DSH allotment amount beginning October 1, 2019 will be available to all remaining DSH eligible hospitals. In the event that the sum of the hospital specific DSH limits of the DSH qualifying hospitals exceeds the sum of DSH payment pool #3 beginning October 1, 2019, the hospital specific DSH limits will be decreased proportionately to ensure the hospital specific DSH limits are within the DSH payment pool #3 amount.

2. The October 1, 2019 - September 30, 2020 annual aggregate DSH payment amounts will not exceed the October 1, 2019 - September 30, 2020 annual DSH allotment amount.

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

FY 2018 2.6%

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

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

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

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

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

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

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

- Total allowable Medicaid cost will be determined at the time of cost settlement by multiplying the adjusted cost to charge ratio as calculated above, by Medicaid charges.

- The interim retrospective cost settlement amount will be determined by subtracting payments received from the allowable 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 interim cost settlement payments, etc.

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

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

- Effective for outpatient hospital services provided on or after October 1, 2016, qualifying hospitals eligible to receive retrospective cost settlements (i.e. SC defined rural hospitals and qualifying burn intensive care unit hospitals) will receive tiered Medicaid reimbursement as follows:

  a) Hospitals designated as SC defined rural hospitals or qualifying burn intensive care unit hospitals prior to October 1, 2014 will receive 100% of their SC Medicaid allowable outpatient reimbursable costs subject to the July 1, 2014 and October 1, 2015 normalization actions;

  b) SC hospitals designated as rural hospitals or as qualifying burn intensive care unit hospitals by the SC Medicaid Program for the first time effective on and after October 1 ,2014 will receive the greater of actual Medicaid reimbursement or 90% of their SC Medicaid allowable outpatient reimbursable costs but not to exceed 100% of their SC Medicaid allowable outpatient reimbursable costs;

  c) SC hospitals designated as rural or as a qualifying burn intensive care unit hospital by the SC Medicaid Program for the first time effective on and after October 1, 2016 will receive the greater of actual Medicaid reimbursement or 80% of their SC Medicaid allowable outpatient reimbursable costs but not to exceed 100% of their SC Medicaid allowable outpatient reimbursable costs.

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

For clarification purposes, all interim retrospective cost settlements will be subject to final audit. Any underpayment/(overpayment) identified as a result of the final audit will be paid or recouped accordingly.

II. Upper Payment Limits:

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

Non-State Owned Governmental and Private Outpatient Hospital Service Providers

The following methodology is used to estimate the upper payment limit applicable to non-state owned governmental and privately owned or operated outpatient hospitals (i.e. for profit and non-governmental nonprofit facilities). State owned psychiatric hospitals do not provide outpatient hospital services so no UPL demonstration is warranted for this class:

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

(1) Medicaid covered outpatient hospital ancillary charges are obtained from the Summary MARS outpatient hospital report. Data source - Summary MARS outpatient hospital report.

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

(3) The total Medicaid outpatient hospital cost determined in step (2) is then trended using the mid-year to mid-year inflation method and the use of the Second Quarter 2019 Global Insight Indexes - 2014 Based CMS hospital PPS Market Basket in order to trend the base year cost (HFY 2018) to the Medicaid rate period October 1, 2019 through September 30, 2020.

(4) Total base year Medicaid outpatient hospital revenue is derived from each hospital's Summary MARS report based upon each hospital's cost reporting period. Data source - Summary MARS outpatient hospital report. Base year revenue will be adjusted accordingly to reflect any rate/payment methodology changes that may have occurred since and during the base year. For hospitals that receive retrospective cost settlements of the estimated revenue for the FFY 2020 payment period will be adjusted accordingly to reflect no more then trended cost as referenced in step (3) subject to the exceptions granted in the July 1, 2014 and October 1, 2015 normalization actions.

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