

**DEPARTMENT OF HEALTH & HUMAN SERVICES**

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



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**Financial Management Group**

June 7, 2022

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

Reference: TN 21-0012

Dear Director Kerr:

We have reviewed the proposed amendment to Attachments 4.19-A and 4.19-B of your Medicaid State Plan submitted under transmittal number (TN) 21-0012.

This State Plan amendment makes changes to the South Carolina Disproportionate Share Hospital (DSH) payment program, Medicaid Inpatient and Outpatient Hospital payment programs, and the Psychiatric Residential Treatment Facility (PRTF) payment program. Specifically, the amendment updates the base year used to calculate interim DSH payments using fiscal year 2020 data, updates the inflation rate used to trend the DSH base year cost to the end of the 2020 calendar year, removes costs associated with services provided to Medicaid-eligible individuals for whom Medicaid is not the primary payor from calculation of hospital-specific DSH limits (dual-eligible claims and Medicaid-eligible claims that have their inpatient or outpatient claim paid by a commercial carrier will be excluded from hospital-specific DSH limit calculation when Medicaid is not the primary payor), updates PRTF reimbursement rates based upon the use of 2019 cost reports and a trend factor, updates swing bed and administrative day rates based on 2021 NF payment rates, updates long-term per diem psychiatric hospital rates based upon the hospital fiscal year 2020 cost reporting period, eliminates the impact of caps and minimums implemented by 2015 normalization actions to inpatient per discharge rates and outpatient hospital multipliers, and amends the South Carolina Medicaid Defined Rural Hospital definition.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1923, and 1903(a) of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C.

This is to inform you that Medicaid State plan amendment SC-21-0012 is approved effective October 1, 2021. The CMS-179 and the plan pages are attached.

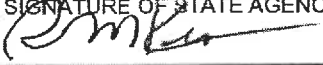
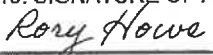
If you have any additional questions or need further assistance, please contact James Francis at [james.francis@cms.hhs.gov](mailto:james.francis@cms.hhs.gov).

Sincerely,

*Rory Howe*

Rory Howe

Director

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE &amp; MEDICAID SERVICES</b>		1. TRANSMITTAL NUMBER <u>2 1 - 0 0 1 2</u>	2. STATE <u>S C</u>
		3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT <input checked="" type="radio"/> XIX <input type="radio"/> XXI	
TO: CENTER DIRECTOR CENTERS FOR MEDICAID & CHIP SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE October 1, 2021	
5. FEDERAL STATUTE/REGULATION CITATION 42 CFR Part 447, Subpart C; Consolidated Approp. Act of 2021		6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars) a. FFY <u>2022</u> \$ <u>11,249,000</u> b. FFY <u>2023</u> \$ <u>11,249,000</u>	
7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT  Attachment 4.19-A, pages 2b, 9, 10, 16, 17, 18, 22, 24, 26a, 26a.1, 26a.2, 26d, 26f, 26g, 27, 28, 28a, 29a, 37, 38, 39  Attachment 4.19-B, pages 1.1, 1.1a (New Page), 1a.2, 1a.3, 1a.4, 1a.6, 1a.8		8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable)  Attachment 4.19-A, pages 2b, 9, 10, 16, 17, 18, 22, 24, 26a, 26a.1, 26a.2, 26d, 26f, 26g; 27, 28, 28a, 29a, 37, 38, 39 Attachment 4.19-B, pages 1.1, 1a.2, 1a.3, 1a.4, 1a.6, 1a.8	
9. SUBJECT OF AMENDMENT  Inpatient Hospital, Outpatient Hospital, Psychiatric Residential Treatment Facilities, and Medicaid DSH Changes Eff. 10/1/2021.			
10. GOVERNOR'S REVIEW (Check One) <input type="radio"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input checked="" type="radio"/> OTHER, AS SPECIFIED: <input type="radio"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="radio"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
11. SIGNATURE OF STATE AGENCY OFFICIAL 		15. RETURN TO South Carolina Department of Health and Human Services Post Office Box 8206 Columbia, SC 29202-8206	
12. TYPED NAME Robert M. Kerr			
13. TITLE Director			
14. DATE SUBMITTED December 17, 2021			
<b>FOR CMS USE ONLY</b>			
16. DATE RECEIVED 12 / 22 / 2021		17. DATE APPROVED June 7, 2022	
<b>PLAN APPROVED - ONE COPY ATTACHED</b>			
18. EFFECTIVE DATE OF APPROVED MATERIAL 10 / 01 / 2021		19. SIGNATURE OF APPROVING OFFICIAL 	
20. TYPED NAME OF APPROVING OFFICIAL Rory Howe		21. TITLE OF APPROVING OFFICIAL Director, Financial Management Group	
22. REMARKS			

- h. Effective for discharges incurred on and after October 1, 2015, the Medicaid Agency will cap the base component of the hospital specific per discharge rates of the SC general acute care hospitals, SC short term psychiatric hospitals, and qualifying out of state border general acute care hospitals that receive a hospital specific per discharge rate at the 65<sup>th</sup> percentile of the October 1, 2014 base rate component of the SC general acute care hospitals and the SC long term acute care hospitals. The Graduate Medical Education (Direct Medical Education and Indirect Medical Education) rate components of the hospital specific per discharge rate will not be impacted by this change. For hospitals whose base component of its hospital specific per discharge rate falls below the 15<sup>th</sup> percentile of the October 1, 2014 base rate component, these hospitals will be reimbursed at the 15<sup>th</sup> percentile base rate component. However, any teaching hospital with a medical education add-on and whose base rate component falls below the 15<sup>th</sup> percentile will continue to receive their current base rate component of their October 1, 2014 hospital specific per discharge rate.

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

- i. Effective for discharges incurred on and after October 1, 2021, the impact of the July 1, 2014 and October 1, 2015 normalization actions will be removed from those hospitals impacted by these actions as described in section C.1.g. and C.1.h. of Attachment 4.19-A.
- j. Effective for services provided on or after October 1, 2012, all SC contracting non-state owned governmental long-term care psychiatric hospitals and all contracting SC long-term psychiatric hospitals owned by the SC Department of Mental Health will receive prospective per diem payment rates.
2. Medicaid reimbursement to a hospital shall be payment in full. Hospitals may not separately bill the patient or the Medicaid program for medical services rendered during an inpatient stay, except as provided in Section III of this plan and/or coinsurance. Hospitals may submit a claim for payment only upon final discharge of the patient, with the exception of long-term care psychiatric hospital claims and psychiatric residential treatment facility claims.
3. Effective for discharges incurred on and after October 1, 2011, inpatient claim payments for all hospitals (except freestanding long-term care psychiatric hospitals) will be made based on a per discharge (per case) rate.
4. Effective for discharges incurred on or after October 1, 2011, the South Carolina Medicaid Program will reimburse inpatient hospital services based on a DRG methodology using the All Patient Refined Diagnosis Related Groups (APR-DRGs) classification system. Qualified providers of inpatient hospital services paid by APR-DRGs include: general acute care hospitals, (including distinct-part units of general hospitals), short-term psychiatric hospitals and long term acute care hospitals. Version 28 of the APR-DRG grouper and corresponding national relative weights (released in October 2010) will be used effective October 1, 2011. The same version with a mapper will be used for October 1, 2012 since there is a code freeze in effect and minimal impact is expected. The DRG grouper then will transition to the ICD-10 compliant APR-DRG version and will be updated each year to the current version.

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

35. Short Term Care Psychiatric Hospital - A licensed, certified hospital providing psychiatric services to patients with average lengths of stay of twenty-five (25) days or less. Patients in these hospitals will be reimbursed through the DRG payment system.
36. South Carolina Defined Rural Hospitals - Effective for inpatient and outpatient hospital services incurred/provided on or after October 1, 2014, the South Carolina Department of Health and Human Services has updated its designation of South Carolina (SC) defined rural hospitals. SC defined rural hospitals will 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  $\leq 130$  Licensed Beds; and SC hospitals located in Equally Rural/Urban ZCTAs with  $\leq 90$  Licensed Beds. ZCTAs are classed as Rural or Urban based on their population designations as defined by the 2010 Census. Each rural/urban classification reflects the relative proportion of ZCTA residents living in rural versus urban areas. These classifications are as follows:

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

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

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

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

37. Special Care Unit - A unit as defined in 42 CFR 413.53 (d).
38. Standard Deviation - The square root of the sum of the squares of the deviation from the mean in a frequency distribution.
39. Teaching Hospital - A licensed certified hospital currently operating an approved intern and resident teaching program or a licensed certified hospital currently operating an approved nursing or allied health education program.

### III. Services Included in the Hybrid Payment System

#### 1. Acute Care Hospitals

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

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

#### 2. Psychiatric Residential Treatment Facilities

The per diem reimbursement rate will be determined in accordance with section V.B. of Attachment 4.19-A.

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

Computation of the October 1, 2015 DRG payment system rates under this plan will require the collection and preparation of the following data elements: per discharge DRG list including relative weights, Medicaid inpatient cost to charge ratios adjusted for April 8, 2011 and July 11, 2011 reimbursement changes, July 1, 2012 through June 30, 2013 incurred inpatient hospital claims, October 1, 2014 inpatient hospital rates adjusted by the October 1, 2015 normalization adjustment, hospital specific add-ons, case mix index, and an upcode adjustment factor.

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

#### A. Per Discharge DRG List

The DRG payment system will establish payment based upon a hospital specific and/or statewide average per discharge rate. Effective for discharges incurred on or after October 1, 2015, the Medicaid Agency will determine inpatient hospital claim payments based upon the DRG listing contained within version 32 of the APR-DRG grouper. Hospitals eligible to receive a hospital specific per discharge rate will include all SC general acute care hospitals, burn intensive care unit hospitals, and out of state border hospitals with SC Medicaid inpatient utilization of at least 200 inpatient claims during its HFY 2011 cost reporting period. Additionally, SC free standing short term psychiatric hospitals and SC long term acute care hospitals, with a minimum SC Medicaid inpatient utilization of at least 10 incurred claims during October 1, 2011 through August 31, 2012, will also receive a hospital specific per discharge rate. All other contracting/enrolled hospitals (i.e. out of state general acute care, new SC general acute care hospitals coming on line after 2011, and all other short term psychiatric and long term acute care hospitals) will receive the appropriate statewide average rate for that type of hospital. The statewide average rate will exclude DME and IME costs.

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- b. Next, the Medicaid Agency established individual hospital specific baseline expenditure targets for each hospital eligible to receive a hospital specific per discharge rate by pricing each hospital's incurred inpatient hospital claims for the July 1, 2012 through June 30, 2013 period against its October 1, 2015 inpatient hospital per discharge rate described in a. above.
- c. Next, as a starting point, an initial estimated hospital specific per discharge rate was established for each hospital and was used to reprice each hospital's incurred inpatient hospital claims for the period July 1, 2012 through June 30, 2013 using the payment criteria reflected below. The total claims payment amount for each hospital was then compared to each hospital's specific baseline expenditure target to determine whether to increase or decrease the initial estimated hospital specific per discharge rate. Model simulations were run for each hospital until each hospital's total claims payment amount, using the final hospital specific per discharge rate and the incurred inpatient hospital claims for the period July 1, 2012 through June 30, 2013, equaled each hospital's specific baseline expenditure target.
1. DRGs as defined by version 32 of the APR-DRG grouper as well as the corresponding national relative weights;
  2. Hospital specific case mix index as determined from the use of the grouper and relative weights as described in 1.a.above;
  3. The effect of the updated cost outlier thresholds as outlined in Section VI (A) of the plan;
  4. Transfers and same day and one day stays reimbursed in accordance with Section VI (B and C) of the plan;
  5. An upcode adjustment factor of two percent (2%) was built within the October 1, 2015 per discharge rates under version 32 of the APR-DRG grouper.
- d. Next, once each teaching hospital's specific per discharge rate was determined in accordance with step c above, the Direct Medical Education and Indirect Medical education components for each hospital was developed by taking the calculated hospital specific per discharge rate in step c and breaking the rate down into three components (i.e. base, DME, and IME) based upon the component percentages of the baseline hospital specific rates effective October 1, 2015 under version 28 of the APR-DRG grouper described in (a) above.
- e. For all other hospitals that did not receive a hospital specific per discharge rate, a statewide per discharge rate was first developed by multiplying the base operating cost component of each hospital receiving a hospital specific per discharge rate by the total number of its discharges used in the October 1, 2015 rate setting (i.e. July 1, 2012 through June 30, 2013 incurred paid claims). Next the sum of the calculated base operating cost amounts for all hospitals was divided by the sum of the discharges for all hospitals to determine the statewide per discharge rate effective October 1, 2015.
- f. For hospitals impacted by the July 1, 2014 and October 1, 2015 normalization actions, the base component of their October 1, 2015 per discharge rates was either increased or decreased based upon the impact of eliminating the normalization actions for discharges incurred on and after October 1, 2021.
- g. The rates described in d, e, and f above are then multiplied by the relative weight for that DRG to calculate the reimbursement for each DRG claim.

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 2<sup>nd</sup> Quarter 2019 Global Insight Indexes - 2016 Based Inpatient Psychiatric Facilities.
- g) For services incurred on and after October 1, 2021, the state owned governmental long-term care psychiatric hospital rates were updated based upon its fiscal year 2020 cost report and trended to the payment period using the midpoint to midpoint methodology and the use of the 3<sup>rd</sup> Quarter 2020 Global Insight Indexes - 2016 Based Inpatient Psychiatric Facilities.
- h) 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.



B. Psychiatric Residential Treatment Facility

Effective for services provided on and after October 1, 2021, a per diem rate will be calculated for each contracting psychiatric residential treatment facility (PRTF) based upon each PRTF's fiscal year end 2019 base year cost and statistical data as reported on the CMS 2552 cost report trended forward to the payment period beginning October 1, 2021 using the midpoint to midpoint trending methodology. Allowable Medicaid reimbursable costs will be determined in accordance with the Provider Reimbursement Manual PRM-15-1 and 42 CFR Part 413. The per diem rate will cover all core PRTF services (including all psychiatric related services that normally would be rendered in an outpatient setting such as in Community Mental Health Clinics or Rehabilitative Behavioral Health Service providers) and room and board costs. All other ancillary costs (including medical ancillary services and psychiatric drugs) will be carved out of the per diem rate and the billing for the ancillary services will become the responsibility of the ancillary provider. No occupancy adjustment will be applied if the base year occupancy rate is less than the statewide average occupancy rate.

The above payment methodology applies to private, non-state owned governmental, and state owned governmental PRTF providers. PRTFs entering the SC Medicaid program on and after October 1, 2021 will receive the statewide average SC Medicaid PRTF 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.

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

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

F. Payment for Administrative Days

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

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

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

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

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

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

- 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 10<sup>th</sup> 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 75<sup>th</sup> percentile cap will be reimbursed the lower of allowable actual Medicaid reimbursable inpatient hospital costs or Medicaid inpatient hospital payments at the 75<sup>th</sup> 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 15<sup>th</sup> 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 65<sup>th</sup> percentile cap will be reimbursed the lower of allowable actual Medicaid reimbursable inpatient hospital costs or Medicaid inpatient hospital payments at the 65<sup>th</sup> 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).
- Effective for discharges incurred on and after January 1, 2020, all SC defined rural hospitals will receive retrospective cost settlements equaling 100% of their SC Medicaid inpatient hospital reimbursable cost subject to the July 1, 2014 and October 1, 2015 normalization actions.
- Effective for discharges incurred on and after October 1, 2021, all SC defined rural hospitals and qualifying burn intensive care unit hospitals will receive retrospective cost settlements equaling 100% of their SC Medicaid inpatient hospital reimbursable costs due to the elimination of the July 1, 2014 and October 1, 2015 normalization actions.

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APPROVAL DATE: 06/07/22

SUPERSEDES: SC 19-0013

N. Upper Payment Limit Calculation

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

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

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

- (1) Covered Medicaid inpatient hospital routine charges are determined by multiplying covered Medicaid inpatient hospital routine billed charges by the ratio of Medicaid Covered days to Medicaid billed days. Data source - Summary MARS inpatient hospital report.
- (2) Covered Medicaid inpatient hospital ancillary charges are determined by multiplying covered Medicaid inpatient hospital ancillary billed charges by the ratio of Medicaid Covered days to Medicaid billed days. Data source - Summary MARS inpatient hospital report.
- (3) Medicaid covered inpatient hospital routine cost is determined by multiplying Medicaid routine days as identified on worksheet S-3, column 7, lines 1, 8 thru 13 and 16 thru 17 by the routine cost per diems determined by the amounts reflected on worksheet B Part I, column 24, lines 30 thru 40 divided by total days of each routine cost center reflected on worksheet S-3, column 8, lines 1 thru 18. Data source - HFY 2552-10 cost report.
- (4) Medicaid covered inpatient hospital ancillary cost is determined by multiplying covered Medicaid inpatient hospital ancillary charges as identified on worksheet D-3, column 2, lines 50 thru 117 by the ancillary cost to charge ratios as reflected on worksheet C, column 8, lines 50 thru 117. Data source - HFY 2552-10 cost report.
- (5) Total Medicaid inpatient hospital cost is determined by combining Medicaid covered inpatient hospital routine cost (step 3) with covered Medicaid inpatient hospital ancillary cost (step 4). The total Medicaid inpatient hospital cost is then trended using the mid-year to mid-year inflation method and the use of the most recent Global Insight Indexes Based CMS Hospital PPS Market Basket in order to trend the base year cost to the FFY 2022 UPL demonstration period.

- (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% of allowable costs on and after October 1, 2021, the estimated revenue equals the trended inflated cost as described in step (5).
- (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 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 use of the most recent Global Insight Indexes Based CMS Hospital PPS Market Basket in order to trend the base year cost to the FFY 2022 UPL demonstration period.
- (4) Total base year Medicaid inpatient hospital revenue is derived from each hospital's DataProbe (SCDHHS Decision Support System) Summary report based upon each hospital's cost reporting period.
- (5) Total projected Medicaid inpatient hospital revenue is determined by taking the October 1, 2021 Medicaid per diem rates multiplied by the HFY 2020 Medicaid days as identified via the DataProbe report.
- (6) The Medicaid UPL compliance check is determined for this class by comparing the aggregate amounts as determined in (3) above to ensure that projected Medicaid inpatient hospital cost is equal to or greater than projected Medicaid inpatient hospital rate expenditures in step 5. In the event that aggregate Medicaid inpatient hospital rate expenditures exceed aggregate Medicaid hospital cost, the Medicaid per discharge rate for each facility will be limited to the Medicaid cost based rate as determined in (3) above.

charge ratios as reflected on worksheet C, column 9, lines 50 through 112. Any ancillary services reflected within these lines (i.e. 50 through 112) that are not considered an inpatient or outpatient hospital service (e.g. home health, ambulance, etc.) will not be reflected within these calculations.

- (2) Covered Medicaid inpatient hospital days used in the UPL calculation are reconciled to the SC MMIS.
- (3) Covered Medicaid inpatient hospital ancillary charges used in the UPL calculations are those that are provider reported and are subject to reconciliation to the SC MMIS if a variance of 3%+ exists between provider reported inpatient ancillary charges versus SC MMIS reported inpatient ancillary charges.
- (4) To determine the UPL gap that will be used to make supplemental payments the amount determined for each hospital in step 1 above will be subtracted from the amount paid to each hospital adjusted for any changes in payment rates during the payment year. The aggregate gap amount for each group of hospitals (private and non-state government) will serve as the basis for the supplemental payments to the private and non-state government hospitals. Furthermore, the supplemental payments available under this section cannot exceed the difference between total Medicaid covered inpatient hospital charges and total allowable Medicaid inpatient revenue received by each hospital eligible to receive UPL reimbursement under this section.
- (5) For payments made for FFY 2022, base year cost will be trended accordingly using the most recent CMS Market Basket rates. Base year cost will be trended using the midpoint to midpoint methodology and the use of the most recent Global Insight CMS Hospital Prospective Reimbursement Quarterly Market Basket Indexes. Medicaid base year revenue will be adjusted accordingly, if applicable, to reflect changes made to SC Medicaid inpatient hospital reimbursement. For subsequent fiscal years, data utilized from the HFY 2552-10 cost report and HFY Summary MARS Report will be no older than 2 years prior to the projected spending year.

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

2. Reimbursement Methodology. Each qualifying hospital shall receive quarterly supplemental enhanced payments for the inpatient services rendered during the quarter. In addition to the limitations resulting from the application of the upper payment limit for hospitals reflected in 42 C.F.R. 447.272(a)-(b), annual supplemental enhanced payments to each qualifying hospital in any Medicaid State Plan rate year shall be limited to the lesser of:
  - a. the difference between the hospital's Medicaid inpatient covered charges and Medicaid payments the hospital receives for services processed for fee-for-service Medicaid recipients during the Medicaid State Plan rate year, including any Medicaid inpatient cost settlement the hospital receives for the Medicaid State Plan rate year under Section VI(I) of the state plan; or
  - b. for hospitals participating in the Medicaid Disproportionate Share Hospital (DSH) Program, the difference between the hospital's hospital specific DSH limit, as defined in Section VII of the state plan, and the hospital's DSH payments during the Medicaid State Plan rate year.
  - c. In the event the payment limitations described in subsections a. or b. exceed the aggregate annual upper payment limit for private hospitals, each qualifying hospital's payment will be proportionately reduced to maintain compliance with the aggregate annual upper payment limit for private hospitals.
3. UPL Calculation for Supplemental Enhanced Payment

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

The most recent HFY 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 the most recent CMS Market Basket rates. For payments made on and after October 1, 2021, base year cost will be trended using the midpoint to midpoint methodology and the use of the most recent Global Insight Based CMS Hospital Prospective Reimbursement Quarterly Market Basket Indexes. Medicaid base year revenue will be adjusted accordingly, if applicable, to reflect changes made to SC Medicaid inpatient hospital reimbursement. For subsequent fiscal years, data utilized from the HFY 2552-10 cost report and HFY Summary MARS Report will be no older than 2 years prior to the projected spending year.

## VII. Disproportionate Share

### A. Payments

Disproportionate share hospital (DSH) payments shall be made in accordance

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## VII. Disproportionate Share

A. Payments

Disproportionate share hospital (DSH) payments shall be made in accordance with the requirements of Section 1923 of the Social Security Act. DSH payments will be paid to those facilities meeting the requirements specified in Section II 12. For clarification purposes, the South Carolina Medicaid State Plan rate year for DSH payment purposes is October 1 through September 30. For FFY 2022, qualification data will be based upon each hospital's fiscal year 2020 cost reporting period.

1. Effective for the October 1, 2021 - September 30, 2022 (FFY 2022) DSH payment period, the interim hospital specific DSH limit will be set as follows:

- a. The interim hospital specific DSH limit for most SC general acute care hospitals that contract with the SC Medicaid Program will be equal to one hundred percent (100%) of the unreimbursed hospital cost for all (i.e. SC and out-of-state) uninsured patients, all Medicaid fee for service patients, and all Medicaid managed care patients (including PACE Program participants). The hospital specific DSH limit of the SC non-general acute care hospitals will equal to sixty percent (60%). The hospital specific DSH limit for all general acute care border hospitals (in North Carolina and Georgia) contracting with the SC Medicaid Program will be equal to sixty percent (60%) of the unreimbursed hospital cost for SC uninsured patients, SC Medicaid fee for service patients, and SC Medicaid managed care patients (including PACE Program participants). Due to certain provisions contained within the Federal Consolidated Appropriations Act of 2021, the FFY 2022 Medicaid Shortfall of the interim hospital specific DSH limits will exclude the costs of Medicaid-eligible patients with third-party sources of coverage, where the third-party source of coverage is the primary payer. The December 19, 2008 Final Rule (as well as instructions/guidance provided by the DSH audit contractor) relating to the audits of the Medicaid DSH plans as well as the December 3, 2014 Final Rule relating to the Uninsured Definition will be the guiding documents that hospitals must use in providing the DSH data.

Except for the SC Department of Mental Health (SCDMH) hospitals, for FFY 2022, each hospital's interim hospital specific DSH limit will be calculated as follows:

- i) The unreimbursed cost of providing inpatient and outpatient hospital services to the uninsured, Medicaid fee for service, and Medicaid MCO enrollees will be determined by taking each hospital's fiscal year 2020 cost reporting period charges for each group listed above and multiplying that by the hospital's applicable FY 2020 unadjusted inpatient and outpatient hospital cost to charge ratios (i.e. Uninsured, Medicaid MCO, and Medicaid FFS) to determine the base year cost for this group. In order to inflate each hospital's

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base year cost determined for each group identified above, each hospital's cost will be inflated from the base year to December 31, 2020 using the applicable CMS Market Basket Index described in (A)(3) of this section. The inflated cost of each hospital for each group determined above will be summed and reduced by payments received from or for all uninsured patients, all Medicaid fee for service, and all Medicaid managed care patients to determine the total unreimbursed cost for each DSH hospital. HFY 2020 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 2022, each SCDMH hospital's interim hospital specific DSH limit will be calculated using FYE June 30, 2020 cost report data for all of its Medicaid fee for service, uninsured, and Medicaid managed care enrollees. Each hospital's total allowable cost will be inflated from the base year to December 31, 2020 using the CMS Market Basket Index described in (A)(3) of this section. The inflated cost will be divided by total FYE June 30, 2020 acute care hospital days to determine a cost per day amount. This cost per day amount will be multiplied by the FYE June 30, 2020 acute care hospital days associated with all Medicaid fee for service, uninsured, and Medicaid managed care enrollees to determine the total amount of cost eligible under the hospital specific DSH limit. The inflated cost of each hospital determined above will be reduced by payments received from or for all Medicaid fee for service, uninsured patients, and Medicaid managed care enrollees to determine the total unreimbursed cost of each DSH hospital. Medicaid fee for service and Medicaid managed care revenue will be adjusted to account for any Medicaid rate increase provided since the base year.
- iii) For new SC general acute care hospitals which enter the SC Medicaid Program during the October 1, 2021 - September 30, 2022 DSH Payment Period, their interim hospital specific DSH limits will be based upon projected DSH qualification, cost, charge and payment data that could be subject to further revision based upon the audited DSH qualification, cost, charge and payment data resulting from the audit of the October 1, 2021 through September 30, 2022 Medicaid State Plan rate year.
- iv) For the FFY 2022 DSH payment period, SC Medicaid-designated rural hospitals in South Carolina shall be eligible to receive up to one hundred percent of costs associated with uncompensated care as part of the DSH program. Funds shall be allocated from the existing DSH program. To be eligible, rural hospitals must participate in reporting and quality guidelines published by the department and outlined in the Healthy Outcomes Initiative.

- v) Effective for the FFY 2022 DSH payment period, the SCDHHS will create three separate DSH pools for the calculation of the interim DSH payments effective October 1, 2021. 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 2022 DSH allotment for the SC defined rural hospitals as described in iv. above. Finally, the remaining DSH allotment amount for FFY 2022 will be available to all remaining DSH eligible hospitals. In the event that the sum of the hospital specific DSH limits of the DSH qualifying hospitals exceeds the sum of DSH payment pool #3 the hospital specific DSH limits will be decreased proportionately to ensure the hospital specific DSH limits are within the DSH payment pool #3 amount.
2. The October 1, 2021 - September 30, 2022 annual aggregate DSH payment amounts will not exceed the October 1, 2021 - September 30, 2022 annual DSH allotment amount.
3. The following CMS Market Basket index will be applied to hospitals' base year cost.
- |         |      |
|---------|------|
| FY 2020 | 3.0% |
|---------|------|
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.

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

- Hospitals designated as SC defined rural hospitals prior to October 1, 2014 will receive 100% of their SC Medicaid inpatient hospital reimbursable cost (Abbeville, Allendale, CHS - Marion, Chester, McLeod Cheraw, Clarendon, Coastal, Colleton, Edgefield, Fairfield, GHS Laurens, Hampton, Lake City, McLeod Dillon, Newberry, and Williamsburg);
- Hospitals designated as a SC defined rural hospital for the first time on and after October 1, 2014 will receive the greater of interim Medicaid fee for service reimbursement or 90% of allowable Medicaid reimbursable inpatient hospital costs, but not to exceed 100% of allowable Medicaid reimbursable costs (Cannon, McLeod Loris, and Union);
- Hospitals designated as a SC defined rural hospital for the first time on and after October 1, 2016 will receive the greater of interim Medicaid fee for service reimbursement or 80% of allowable Medicaid reimbursable inpatient hospital costs, but not to exceed 100% of allowable Medicaid reimbursable costs (The Regional Medical Center).

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

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

Cost of the Uninsured

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

A base year will be used to calculate the cost of the SC uninsured, and Medicaid managed care enrollees. The base year will be the SCDMH hospitals fiscal year end beginning two years prior to the reporting year (ex. 2009 data for federal fiscal year (FFY) 2011 DSH payments). Interim DSH Limit for each SCDMH hospital will be the estimated uncompensated care for inpatient hospital services provided to all individuals with no source of third party insurance (i.e. SC and out-of state uninsured), Medicaid fee for service individuals, plus the uncompensated care (including potential surplus) for inpatient hospital services provided to Medicaid managed care enrollees. Due to certain provisions contained within the Federal Consolidated Appropriations Act of 2021, the FFY 2022 Medicaid Shortfall of the interim hospital specific DSH limits will exclude the costs of Medicaid-eligible patients with third-party sources of coverage, where the third-party source of coverage is the primary payer.

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

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

payment purposes. The state will determine each SCDMH hospital's DSH eligible routine per diem cost by first summing the inpatient hospital routine service cost centers. These amounts will be derived from worksheet B, Part I, column 24 (which includes GME cost, if applicable). Total inpatient hospital days and subprovider days (if applicable) will be obtained from Worksheet S-3, Part 1. Any subprovider cost identified as a non inpatient hospital cost (e.g. Psychiatric Residential Treatment Facility (PRTF)) will be excluded from the calculation of the inpatient hospital's routine cost. Next, in order to determine the DSH eligible inpatient hospital ancillary service costs associated with all uninsured, Medicaid fee for service, and Medicaid managed care enrollees, covered inpatient ancillary charges by ancillary cost center and payor class obtained from the annual SC Medicaid DSH Survey will be multiplied by the applicable "cost" cost to charge ratio(s) by ancillary cost center reflected on Worksheet C. Therefore, to determine each hospital's DSH eligible allowable inpatient hospital cost, the DSH eligible routine per diem cost will be multiplied by all DSH eligible inpatient days to determine allowable DSH eligible inpatient hospital routine costs. The DSH eligible days will be obtained from the annual SC Medicaid DSH Survey. The DSH eligible allowable inpatient hospital routine cost will then be added to the DSH eligible allowable inpatient ancillary costs to determine total allowable DSH eligible inpatient hospital costs.

- b) The inpatient hospital cost associated with the South Carolina uninsured and Medicaid eligibles as described above will be trended using the CMS Market Basket Index as described in section VII. of Attachment 4.19-A. The trended cost will then be reduced by payments received from uninsured patients as well as payments received on behalf of inpatient hospital services provided to Medicaid eligibles as described above to determine each hospital's estimated maximum amount of uncompensated care costs to be reimbursed during the DSH payment period.
- c) The uncompensated care cost as described above will be used in the development of the interim DSH payment amount as described in section VII of Attachment 4.19-A.
- d) Final Reconciliation of Interim Medicaid DSH Payments Post Reporting Year: Upon issuance of a Final Audit Report by the Agency's audit contractor beginning with the October 1, 2010 DSH Payment Program, the Agency will determine each SCDMH hospital's audited DSH eligible routine per diem cost by first summing the inpatient hospital routine service cost centers. These amounts will be derived from worksheet B, Part I, column 24 (which includes GME cost, if applicable). Total inpatient hospital days and subprovider days (if applicable) will be obtained from Worksheet S-3, Part 1. Any subprovider cost identified as a non inpatient hospital cost (e.g. Psychiatric Residential Treatment Facility (PRTF)) will be excluded from the calculation of the inpatient

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



- For all hospitals eligible to receive its individual hospital specific outpatient multiplier effective for services provided on or after October 1, 2015, the Medicaid Agency will cap the hospital specific outpatient hospital multipliers at the 65<sup>th</sup> percentile of the October 1, 2014 hospital specific outpatient hospital multipliers of the SC general acute care hospitals, the SC long term acute care hospitals, and the qualifying out of state border general acute care hospitals which receive its own hospital specific outpatient hospital multiplier. The Graduate Medical Education (Direct Medical Education) component of the hospital specific outpatient multipliers will not be impacted by this change. For hospitals whose hospital specific outpatient multiplier falls below the 15<sup>th</sup> percentile, these hospitals will be reimbursed at the 15<sup>th</sup> percentile hospital specific outpatient multiplier. However, any teaching hospital whose hospital specific outpatient multiplier falls below the 15<sup>th</sup> percentile will continue to receive its October 1, 2014 hospital specific outpatient multiplier.

For hospitals that are eligible to receive retrospective cost reimbursement and fall under the 15<sup>th</sup> percentile, these hospitals will be eligible to receive Medicaid outpatient hospital reimbursement in excess of cost subject to aggregate upper payment limitations. Conversely, hospitals that are eligible to receive retrospective cost settlement and are capped by the 65<sup>th</sup> percentile methodology will be reimbursed the lower of allowable actual Medicaid reimbursable outpatient hospital costs or Medicaid outpatient hospital payments at the 65<sup>th</sup> percentile for services provided on or after October 1, 2015.

- Effective for services provided on and after October 1, 2021, the impact of the July 1, 2014 and October 1, 2015 normalization actions will be removed from those hospitals impacted by these actions as outlined in Bullet #4 of page 1 and Bullet #1 of page 1.1 of Attachment 4.19-B. Therefore effective for services provided on and after October 1, 2021, SC defined rural hospitals and qualifying burn intensive care unit hospitals will receive 100% of its allowable Medicaid reimbursable costs on a retrospective basis.
- Effective for outpatient hospital services provided on or after October 1, 2014, the South Carolina Department of Health and Human Services has updated its current designation of South Carolina (SC) defined rural hospitals with the following SC defined rural hospital criteria:

SC defined rural hospitals will include all SC Critical Access Hospitals (CAH); all SC hospitals located in the state's Zip Code Tabulation Areas (ZCTAs) classified as Moderately Rural/Rural; all SC hospitals located in Primary Care Health Professional Shortage Areas (HPSAs) for Total Population; SC hospitals located in Persistent Poverty Counties with ≤130 Licensed Beds; and SC hospitals located in Equally Rural/Urban ZCTAs with ≤90 Licensed Beds. ZCTAs are classed as Rural or Urban based on their population designations as defined by the 2010 Census. Each rural/urban classification reflects the relative proportion of ZCTA residents living in rural versus urban areas. These classifications are as follows.

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

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

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

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

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for qualifying out of state border general acute care hospitals was increased by 2.50%. However, for SC general acute care hospitals as defined in Attachment 4.19-A, the DME portion of the hospital specific outpatient multiplier was not subject to the 2.50% increase. DME costs continue to be non-reimbursable for out of state border general acute care teaching hospitals.

Effective for services provided on or after November 1, 2012, all SC general acute care hospitals designated as SC critical access hospitals, SC isolated rural and small rural hospitals, certain SC large rural hospitals located in a Health Professional Shortage Area (HPSA) for primary care for total population, SC large rural hospitals as defined by Rural/Urban Commuting Area classes with an average of 35 full time equivalent occupied beds or less based upon hospital fiscal year 2008 thru 2011 cost report census data and qualifying burn intensive care unit hospitals which contract with the SC Medicaid Program will have its November 1, 2012 hospital specific outpatient multiplier calculated to reflect the impact of the July 11, 2011 payment reductions (i.e. 97% of allowable Medicaid targeted costs including DME). Effective for services occurring on or after October 1, 2013, the November 1, 2012 hospital specific outpatient multiplier was increased by 2.75% for all SC defined rural hospitals and burn intensive care unit hospitals which qualify for retrospective cost settlement.

For all hospitals eligible to receive a hospital specific outpatient multiplier effective for services provided on or after July 1, 2014, the Medicaid Agency will cap the hospital specific outpatient hospital multipliers at the 75<sup>th</sup> percentile of the October 1, 2013 hospital specific outpatient hospital multipliers of the SC general acute care hospitals, the SC long term acute care hospitals, and the qualifying out of state border general acute care hospitals which receive its own hospital specific outpatient hospital multiplier. The Graduate Medical Education (Direct Medical Education) component of the hospital specific outpatient multipliers will not be impacted by this change. For hospitals whose hospital specific outpatient multiplier falls below the 10<sup>th</sup> percentile, these hospitals will be reimbursed at the 10<sup>th</sup> percentile hospital specific outpatient multiplier. However, any teaching hospital whose hospital specific outpatient multiplier falls below the 10<sup>th</sup> percentile will continue to receive its October 1, 2013 hospital specific outpatient multiplier.

For all hospitals eligible to receive its individual hospital specific outpatient multiplier effective for services provided on or after October 1, 2015, the Medicaid Agency will cap the hospital specific outpatient hospital multipliers at the 65<sup>th</sup> percentile of the October 1, 2014 hospital specific outpatient hospital multipliers of the SC general acute care hospitals, the SC long term acute care hospitals, and the qualifying out of state border general acute care hospitals which receive its own hospital specific outpatient hospital multiplier. The Graduate Medical Education (Direct Medical Education) component of the hospital specific outpatient multipliers will not be impacted by this change. For hospitals whose hospital specific outpatient multiplier falls below the 15<sup>th</sup> percentile, these hospitals will be reimbursed at the 15<sup>th</sup> percentile hospital specific outpatient multiplier. However, any teaching hospital whose hospital specific outpatient multiplier falls below the 15<sup>th</sup> percentile will continue to receive its October 1, 2014 hospital specific outpatient multiplier.

Effective for services provided on and after October 1, 2021, the impact of the July 1, 2014 and October 1, 2015 normalization actions will be removed from those hospitals impacted by these actions as outlined in Bullet #4 of page 1 and Bullet #1 of page 1.1 of Attachment 4.19-B.

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Effective for outpatient hospital services provided on or after October 1, 2014, the South Carolina Department of Health and Human Services has updated its current designation of South Carolina (SC) defined rural hospitals with the following SC defined rural hospital criteria:

SC defined rural hospitals will include all SC Critical Access Hospitals (CAH); all SC hospitals located in the state's Zip Code Tabulation Areas (ZCTAs) classified as Moderately Rural/Rural; all SC hospitals located in Primary Care Health Professional Shortage Areas (HPSAs) for Total Population; SC hospitals located in Persistent Poverty Counties with  $\leq 130$  Licensed Beds; and SC hospitals located in Equally Rural/Urban ZCTAs with  $\leq 90$  Licensed Beds. ZCTAs are classed as Rural or Urban based on their population designations as defined by the 2010 Census. Each rural/urban classification reflects the relative proportion of ZCTA residents living in rural versus urban areas. These classifications are as follows:

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

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

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

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

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

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

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

- a) The hospital specific outpatient multipliers will continue to be calculated so that outpatient hospital reimbursement approximates the Department's specified percent of allowable Medicaid costs for each eligible hospital as described under the section titled "Determination of Hospital Specific Outpatient Multipliers".
- b) A cost to charge ratio will be calculated for Medicaid outpatient hospital services. This ratio will be calculated using cost from worksheet B Part 1 Column 24, charges from worksheet C Column 8, and Medicaid cost settled ancillary charges obtained from the Medicaid Management and Administration Reporting System (MARS) identified on worksheet D part V column 3. The Medicaid outpatient hospital cost-to-charge ratio will be determined by taking the sum of the SC Medicaid outpatient ancillary costs and dividing this amount by the sum of the SC Medicaid covered outpatient ancillary charges. Charges not covered by the hospital payment system, such as CRNA and ambulance, must be excluded from this calculation. Effective for services provided on or after July 11, 2011, two cost to charge ratios will be determined for teaching hospitals. The first cost to charge ratio will be determined

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on base and all capital related costs except those associated with DME capital costs using the methodology previously described. The second cost to charge ratio will be determined using DME costs only (including the capital portion of DME Costs) using the methodology previously described. The applicable reductions (i.e. 93% or 97% to base and capital and 100% or 87.3% to DME) will be applied to the calculated cost for each cost pool and an adjusted cost/charge ratio will be determined.

- c) Next, each hospital's cost to charge ratio will be further adjusted upward or downward for the effect of the Hospital Fiscal Year (HFY) 2010 audit adjustment factor. The HFY 2010 audit adjustment factor is determined by dividing the audited HFY 2010 Medicaid outpatient cost to charge ratio by the interim adjusted HFY 2010 Medicaid outpatient hospital cost to charge ratio.
- d) The adjusted hospital fiscal year 2011 Medicaid outpatient hospital cost to charge ratio for each hospital, as described above in b) and c), is multiplied by each hospital's Medicaid outpatient hospital allowed charges based upon services provided during the period October 1, 2011 through June 30, 2012.
- e) The Medicaid allowable outpatient cost determined in d) above is reduced by one and a half percent (1.5%) to determine the cost target to be used for each eligible hospital to receive a hospital specific outpatient multiplier. The one and a half percent reduction is applied to take into account the difference between the cost report year and the claims data period.
- f) The Medicaid cost target for each hospital determined in e) above will then be compared to each hospital's corresponding base Medicaid fee for service claims payments (including co-pay and TPL) prior to the application of the hospital specific outpatient multiplier in effect during the payment period outlined in d) above to determine the hospital specific outpatient multiplier effective November 1, 2012. To determine the base Medicaid fee for service claims payments for services provided on and after October 1, 2011 during the October 1, 2011 through June 30, 2012 claims payment period prior to the application for the hospital specific outpatient multiplier, the claim payments for this period are divided by the October 1, 2011 hospital specific outpatient multiplier. A further adjustment to base Medicaid fee for service claims revenue was made for a 75% reduction in OP therapy rates.
- g) Effective for services occurring on or after October 1, 2013, the November 1, 2012 hospital specific outpatient multiplier was increased by 2.75% for all SC general acute care non-teaching hospitals and qualifying out of state border general acute care teaching and non-teaching hospitals. Effective for services occurring on or after October 1, 2013, the November 1, 2012 hospital specific outpatient multiplier for all SC teaching hospitals as defined by Attachment 4.19-A was increased by the proportion of Medicaid outpatient DME costs to total Medicaid outpatient costs (including DME) multiplied by 2.75%. For all hospitals eligible to receive its individual hospital specific outpatient multiplier effective for services provided on or after July 1, 2014, the Medicaid Agency will cap the hospital specific outpatient hospital multipliers at the 75<sup>th</sup> percentile of the October 1, 2013 hospital specific outpatient hospital multipliers of the SC general acute care hospitals, the SC long term acute care hospitals, and the qualifying out of state border general acute care hospitals which receive its own hospital specific outpatient hospital multiplier. The Graduate Medical Education (Direct Medical Education) component of the hospital specific outpatient multipliers will not be impacted by this change. For hospitals whose hospital specific outpatient multiplier falls below the 10<sup>th</sup> percentile, these hospitals will be reimbursed at the 10<sup>th</sup> percentile hospital specific outpatient multiplier. However, any teaching hospital whose hospital specific

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

- j) Effective for services provided on and after October 1, 2021, the impact of the July 1, 2014 and October 1, 2015 normalization actions will be removed from those hospitals impacted by these actions as outlined in Bullet #4 of page 1 and Bullet #1 of page 1.1 of Attachment 4.19-B.

Clinical Lab Fee Schedule:

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

Retrospective Hospital Cost Settlement Methodology:

Effective October 1, 2013, the following methodology describes the outpatient hospital retrospective cost settlement process for qualifying hospitals. The source document for Medicaid allowable outpatient costs will be the CMS-2552, which is the Medicare/Medicaid cost report. Allowable Medicaid outpatient costs will be determined in accordance with the Provider Reimbursement Manual Publication 15. However, for clarification purposes, one hundred percent (100%) of the South Carolina General acute care hospital provider tax will be considered an allowable Medicaid costs. Effective October 1, 2010, outpatient hospital clinical lab services will no longer be retrospectively cost settled.

- A cost to charge ratio will be calculated for Medicaid outpatient claims. This ratio will be calculated using cost from worksheet B part I, charges from worksheet C, and Medicaid settlement data from worksheet D part V. For ancillary cost centers, a cost-to-charge ratio will be calculated by dividing cost as reported on worksheet B part I by total charges from worksheet C. Medicaid cost for each ancillary cost center will be determined by multiplying this ratio by Medicaid charges as reported on worksheet D part V. Charges not covered by the hospital payment system, such as CRNA and ambulance, must be excluded from this calculation.

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- Effective for discharges incurred on and after January 1, 2020, all SC defined rural hospitals will receive retrospective cost settlements equaling 100% of their SC Medicaid outpatient hospital reimbursable cost subject to the July 1, 2014 and October 1, 2015 normalization actions.
- Effective for services provided on and after October 1, 2021, the impact of the July 1, 2014 and October 1, 2015 normalization actions will be removed from those hospitals impacted by these actions as outlined in Bullet #4 of page 1 and Bullet #1 of page 1.1. of Attachment 4.19-B. Therefore effective for services provided on and after October 1, 2021, SC defined rural hospitals and qualifying burn intensive care unit hospitals will receive 100% of its allowable Medicaid reimbursable costs on a retrospective basis.

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

## II. Upper Payment Limits:

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

### Non-State Owned Governmental and Private Outpatient Hospital Service Providers

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

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

- (1) Medicaid covered outpatient hospital ancillary charges are obtained from the Summary MARS outpatient hospital report. Data source - Summary MARS outpatient hospital report.
- (2) Medicaid covered outpatient hospital ancillary cost is determined by multiplying covered Medicaid outpatient hospital ancillary charges as identified on worksheet D Part V, column 3, lines 50 thru 117 by the ancillary cost to charge ratios as reflected on worksheet C, column 8, lines 50 thru 117. Data source - HFY 2552-10 cost report.
- (3) The total Medicaid outpatient hospital cost determined in step (2) is then trended using the mid-year to mid-year inflation method and the use of the Third Quarter 2020 Global Insight Indexes - 2014 Based CMS hospital PPS Market Basket in order to trend the base year cost to the FFY 2021 UPL demonstration period.

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