DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Atlanta Regional Office
61 Forsyth Street, Suite 4T20
Atlanta, Georgia 30303

CENTERS FOR MEDICARE & MEDICAID SERVICES

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

May 11, 2016

Mr. Christian L. Soura
Director
SC Department of Health and Human Services
Post Office Box 8206
Columbia, South Carolina 29202-8206

Attention: Sheila Chavis

RE: Title XIX State Plan Amendment, SC 14-021

Dear Mr. Soura:

We have reviewed the proposed State Plan Amendment, SC 14-021, which was submitted to the Atlanta Regional Office on December 12, 2014. This plan amendment updates the outpatient hospital multiplier. Specifically, the following changes are being made: (1) update the base portion of the September 30, 2014 hospital specific outpatient multiplier by 2.50 percent for all South Carolina general acute care hospitals with the exception of Direct Medical Education; (2) update the base portion of the September 30, 2014 hospital specific multiplier by 2.50 percent for all qualifying out of state border general acute care hospitals entitled to receive a hospital specific outpatient multiplier; (3) update the designation of South Carolina defined rural hospital; (4) South Carolina defined rural and burn intensive care unit hospitals will receive retrospective cost settlements that will equate to 100 percent of allowable Medicaid costs.

Based on the information provided, the Medicaid State Plan Amendment SC 14-021 was approved on May 11, 2016. The effective date of this amendment is October 1, 2014. We are enclosing the approved HCFA-179 and the plan pages.

If you have any additional questions or need further assistance, please contact Cheryl Wigfall at (803) 252-7299.

Sincerely,

Melanie Johnson
for

Jackie Glaze
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosures

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: 14-021

2. STATE: South Carolina

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

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

4. PROPOSED EFFECTIVE DATE
October 1, 2014

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 Subpart C

7. FEDERAL BUDGET IMPACT: (@70.64%)
a. FFY 2015 $2,069,810
b. FFY 2016 $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-B, pages , 1.1, 1a, 1a.1, 1a.2, 1a.3, 1a.4, 1a.5 & 1a.6(new page)

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

Attachment 4.19-B, pages 1.1, 1a, 1a.1, 1a.2, 1a.3, 1a.4, & 1a.5

10. SUBJECT OF AMENDMENT:
Outpatient Hospital Multiplier Update Effective October 1, 2014.

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

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Christian L. Soura

14. TITLE:
Interim Director

15. DATE SUBMITTED:
December 10, 2014

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: 12/12/14

18. DATE APPROVED: 05/11/16

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
10/01/14

20. SIGNATURE OF REGIONAL OFFICIAL:
Melanie Johnson for J. Glaze

21. TYPED NAME: Jackie Glaze

22. TITLE: Associate Regional Administrator
Division of Medicaid & Children Health Opns

23. REMARKS: Approved with the following changes to blocks 8 and 9 as authorized by state on email dated:03/10/16:

Block # 8 changed to read: Attachment 4.19-B pages 1.1, 1a, 1a.1, 1a.2, 1a.3, 1a.4, 1a.5, 1a.6 and 1a.7.

Block # 9 changed to read: Attachment 4.19-B pages 1.1, 1a, 1a.1, 1a.2, 1a.3, 1a.4 and 1a.5.

For hospitals that are eligible to receive retrospective cost reimbursement and fall under the 10th 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 75th percentile methodology will be reimbursed the lower of allowable actual Medicaid reimbursable outpatient hospital costs or Medicaid outpatient hospital payments at the 75th percentile for services provided on or after July 1, 2014.

- 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.

  Therefore, effective for outpatient hospital services provided on or after October 1, 2014, the SC hospitals meeting this SC defined rural hospital criteria will receive retrospective cost settlements that represent one hundred percent (100%) of allowable SC Medicaid outpatient hospital costs which includes, base, capital, and Direct Medical Education (DME) costs subject to the exceptions provided in the July 1, 2014 outpatient hospital normalization action.

Determination of the Statewide Outpatient Hospital Fee Schedule Rates:

The October 1, 2007 statewide outpatient hospital fee schedule rates for acute care and long term acute care hospitals will be based upon the allowable outpatient cost information of covered services from each acute care hospital's FY 2005 cost report. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of outpatient hospital services. The agency's fee schedule rate was set as of October 1, 2007 and is effective for services provided on or after that date. All rates are published on the agency's website. All contracting SC acute care hospitals as well as out of state contracting border hospitals with SC Medicaid fee for service inpatient claims utilization of at least 200 claims were used in this analysis. 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 cost. Outpatient allowable costs, charges and statistics will be extracted from the cost report and prepared for the rate computations using the following general guidelines. The FY 2005 SCDHHS Management and Administration Reporting System (MARS) paid claims summary data report for each acute care hospital identified above will also be used during the analysis.

- As filed total facility costs are identified from each facility's FY 2005 Worksheet B Part I (BI) CMS-2552 cost report. Total outpatient facility costs would include operating, capital, and direct medical education. CRNA costs identified under BI, column 20 are removed from allowable costs. Observation cost is reclassified.

- As filed total facility costs will be allocated to Medicaid outpatient hospital cost using the following method:

  A cost-to-charge ratio for each ancillary service will be computed by dividing total costs as adjusted in this section by total charges as reported on Worksheet C. This cost-to-charge ratio will then be multiplied by SC Medicaid covered charges (as reported on Worksheet D Part V for Medicaid outpatient ancillary charges) to yield total SC Medicaid outpatient ancillary costs. The SC Medicaid outpatient 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 outpatient covered ancillary charges. The SC Medicaid outpatient cost-to-charge ratio will then be multiplied by the facility's SC Medicaid covered outpatient charges as identified on the SCDHHS MARS summary paid claims data report to determine each hospital's allowable SC Medicaid outpatient cost for FY 2005.

- The allowable Medicaid outpatient costs are summed to determine the aggregate Medicaid outpatient costs for FY 2005. An aggregate Medicaid allowable cost target was established at 95% of allowable Medicaid outpatient costs.

- After establishing the FY 2005 aggregate Medicaid allowable cost target, several actuarial models were developed and FY 2005 outpatient claims were repriced to determine the uniform increase in the statewide outpatient fee schedule rates. In order to trend the rates to the period October 1, 2007 through September 30, 2008, a 3.5% annual trend factor was applied. As a result of these steps, the statewide outpatient fee schedule rates increased by 135% effective October 1, 2007.

  Determination of Hospital Specific Outpatient Multipliers:
  In order to convert the statewide outpatient fee schedule rate payment into a hospital specific payment, an outpatient multiplier will be developed for each hospital. The outpatient multiplier will adjust the calculated statewide outpatient fee schedule claims payment to a hospital specific payment and will represent the projected outpatient costs calculated in accordance with Agency defined criteria effective November 1, 2012 and incorporate the impact of the July 11, 2011 payment reductions for the classes of hospitals outlined in this and the following three paragraphs. Hospitals that receive a hospital specific outpatient multiplier will be those eligible to receive retrospective cost settlements and those SC general acute care hospitals that no longer are eligible to receive retrospective cost settlements effective for services provided on or after November 1, 2012 as well as qualifying out of state border hospitals that have S C Medicaid fee for service inpatient claims utilization of at least 200 claims.

  Effective for services provided on or after November 1, 2012, all SC general acute care hospitals except those 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. 93% of allowable Medicaid targeted base costs less Direct Medical Education (DME)). Additionally, the hospital

specific multipliers of the SC general acute care hospitals identified above with interns/residents and allied health alliance training programs will be further adjusted to account for the allowance of eighty-seven.three percent (87.3%) of allowable SC Medicaid outpatient hospital DME costs (including the DME capital related costs).Effective for services occurring on or after October 1, 2013, the base portion of the November 1, 2012 hospital specific outpatient multiplier was increased by 2.75% for all SC general acute care hospitals. However, for SC general acute care teaching hospitals as defined in Attachment 4.19-A, the DME portion of the November 1, 2012 hospital specific outpatient multipliers was not subject to the 2.75% increase. Effective for services provided on or after October 1, 2014, the base portion of the September 30, 2014 hospital specific outpatient multipliers for all SC general acute care hospitals were 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.

Effective for services provided on or after November 1, 2012, qualifying out of state border hospitals that have SC Medicaid fee for service claim utilization of at least 200 claims will have its November 1, 2012 hospital specific outpatient multiplier calculated to reflect the impact of the July 11, 2011 payment reductions (i.e. 93% of allowable Medicaid targeted base costs less DME). Additionally, the hospital specific outpatient multipliers of the out of state border hospitals identified above with interns/residents and allied health alliance training programs will be further adjusted to account for DME costs (including the capital related costs) no longer being reimbursed to qualifying out of state border hospitals. Effective for services occurring on or after October 1, 2013, the base portion of the November 1, 2012 hospital specific outpatient multiplier was increased by 2.75% for qualifying out of state border general acute care hospitals. Effective for services provided on or after October 1, 2014, the base portion of the September 30, 2014 hospital specific outpatient multipliers 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 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 75th 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 10th percentile, these hospitals will be reimbursed at the 10th percentile hospital specific outpatient multiplier. However, any teaching hospital whose hospital specific outpatient multiplier falls below the 10th percentile will continue to receive its October 1, 2013 hospital specific outpatient multiplier.

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.

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 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 October 1, 2013

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 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 outpatient (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 75th 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 10th percentile, these hospitals will be reimbursed at the 10th percentile hospital specific outpatient multiplier. However, any teaching hospital whose hospital specific outpatient multiplier falls below the 10th percentile will continue to receive its October 1, 2013 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.

h) Effective for services occurring on or after October 1, 2014, the base portion of the September 30, 2014 hospital specific outpatient multipliers was increased by 2.50% 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, 2014, the base portion of the September 30, 2014 hospital specific outpatient multiplier for all SC teaching hospitals as defined by Attachment 4.19-A was increased by the proportion of total outpatient DME costs to total outpatient costs (including DME) multiplied by 2.50%. 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 75th 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 hospital 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 10th percentile, these hospitals will be reimbursed at the 10th percentile hospital specific outpatient multiplier. However, any teaching hospital whose hospital specific outpatient multiplier falls below the 10th percentile will continue to receive its October 1, 2013 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.

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 services. This ratio will be calculated using cost from worksheet B part I (column 24, applicable lines from 50-117), charges from worksheet C (column 8), and Medicaid settlement data from worksheet D part V (columns 2, 3, and 4). 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.

- 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 settlement 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 for services provided on or after July 1, 2014.

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 Medicare Inpatient Hospital Market Basket Index rate (prior to productivity adjustment) for FY 13, FY 14, and FY 15 in order to trend the base year cost (HFY 2013) to the Medicaid rate period October 1, 2014 through September 30, 2015.

(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.

(5) Next, the Department divided the Medicaid outpatient hospital revenue for each hospital by the weighted average hospital specific outpatient multipliers based upon the October 1, 2011, November 1, 2012, and October 1, 2013 multipliers to determine the Statewide Outpatient Hospital Fee Schedule payments received by each hospital during the base year period.

(6) Next, to account for the October 1, 2014 hospital specific outpatient multiplier update, the Department multiplied the October 1, 2014 hospital specific outpatient multipliers against the Statewide Outpatient Hospital Fee Schedule payments received by each hospital during the base year (see step (5))to determine projected Medicaid outpatient hospital revenue for FFY 2015. For hospitals that continue to receive retrospective cost settlements at 100% of allowable costs on and after October 1, 2014, the estimated revenue for the FFY 2015 payment period equals the trended inflated cost as described in step (3) subject to the exceptions granted in the July 1, 2014 normalization action.

(7) 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 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).

Cost Report Requirements:

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

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

Co-payment Requirements:

Emergency services are not subject to co-payment. The outpatient cost settlement payment calculation will include uncollected Medicaid co-payment amounts in accordance with 42 CFR 447.57.

B. Objectives

Implementation of the reimbursement methodology provided herein has the following objectives: