DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

EA

TO	DATE
Singleton/Clavis	10-15-14

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 000082	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR cc: McKee, Kost, Depo, CMS file	[ ] Prepare reply for appropriate signature DATE DUE _____ [ ] FOIA DATE DUE _____ [X] Necessary Action

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
1.			
2.			
3.			
4.			

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

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

Financial Management Group

OCT 10 2014

Mr. Anthony E. Keck
Director
Department of Health and Human Services
P.O. Box 8206
Columbia, South Carolina 29202-8206

RE: State Plan Amendment SC 11-022

Dear Mr. Keck:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid state plan submitted under transmittal number (TN) 11-022. Effective October 1, 2011 this amendment proposes to revise the payment methodology for inpatient hospital services. Specifically the amendment proposes to make enhanced supplemental payments to non-state government and private hospitals up the upper payment limit. Funding for the nonfederal share will be provided by intergovernmental transfer of funds from Spartanburg Regional Health Services District.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a), 1902(a)(13), 1902(a)(30), 1903(a), 1923 and 1903(w) of the Social Security Act and the implementing Federal regulations at 42 CFR Part 447. Approval of this amendment is conditioned on your assurance that payments to the providers are not dependent on any agreement or arrangement for providers or related entities to donate money or services to a government provider. In addition payments will not be made until CMS has approved the upper payment limit demonstration each state fiscal year. We have found that the proposed changes in payment methodology comply with applicable requirements and therefore have approved them with an effective date of October 1, 2011. We are enclosing the CMS-179 and the amended approved plan pages.

If you have any questions, please call Stanley Fields at (502) 223-5332.

Sincerely,

Timothy Hill
Director

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: SC 11-022

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
10/01/11

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

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

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

6. FEDERAL STATUTE/REGULATION CITATION:

42 CFR Part 447 Subpart C

7. FEDERAL BUDGET IMPACT: FMAP .7024 of $40,000,000
a. FFY 2012 $28,096,000
b. FFY 2013 $28,096,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-A, pages 4, 25, 26b and 29a

See additional comments in box 23

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

Attachment 4.19-A, pages 4, 25 and 29a

See additional comments in box 23

10. SUBJECT OF AMENDMENT:
Creating an Upper Payment Limit Program for SC for qualifying private hospitals who are affiliated with a state or unit of local government through a Low Income Needy Patient Care Collaboration Agreement for purposes of providing healthcare services to low income and needy Medicaid patients.

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. Keck was designated by the Governor to review and approve all State Plans

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Anthony E. Keck

14. TITLE:
Director

15. DATE SUBMITTED:
October 28, 2011

16. RETURN TO:

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

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: OCT 10 2014

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
OCT 01 2011

20. SIGNATURE OF REGIONAL OFFICIAL:
Kristin Fan

21. TYPED NAME: Kristin Fan

22. TITLE: Deputy Director, FMG

23. REMARKS:

Pen & Ink authorized changes to the 179

Block 7	FFY 2012 $24,795,000; FFY 2013 $24,862,000.
Block 8	Added pages 23, 26a, 26c, 26d, 26e and 26f
Block 9	add page 23.

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

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

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

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

1. Administrative Days - The days of service provided to recipients who no longer require acute hospital care, but are in need of nursing home placement that is not available at the time. The patient must meet either intermediate or skilled level of care criteria.

2. Arithmetic Mean (average) - The product of dividing a sum by the number of its observations.

3. Base Year - The fiscal year used for calculation of payment rates. For the hybrid payment system rates effective on and after July 11, 2011, the base year shall be each facility's 2006 fiscal year. For the freestanding long-term psychiatric hospital rates, the base year shall be each facility's 1990 fiscal year.

4. Burn Intensive Care Unit Cost Settlement Criteria - In order to qualify for this cost settlement a hospital must satisfy all of the following criteria. A hospital must:

   - Be located in South Carolina or within 25 miles of the South Carolina border;
   - Have a current contract with the South Carolina Medicaid Program; and
   - Have at least 25 beds in its burn intensive care unit.

5. Capital - Cost associated with the capital costs of the facility. Capital costs include, but are not limited to, depreciation, interest, property taxes, property insurance, and directly assigned departmental capital lease costs. In no case shall the capital amount include amounts reflecting revaluation of assets due to change of ownership or leasing arrangement subsequent to September 1, 1984.

6. Case-Mix Index - A relative measure of resource utilization at a hospital.

7. Cost - Total SC Medicaid allowable costs of inpatient services, unless otherwise specified.

8. CRNA - Certified Registered Nurse Anesthetist.

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

10. Direct Medical Education Cost - Those direct costs associated with an approved intern and resident or nursing school teaching program as defined in the Medicare Provider Reimbursement Manual, publication HIM-15.

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

G. Payment for One-Day Stay

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

H. New Facilities/New Medicaid Providers

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

a. For hospitals under the DRG payment system, the per discharge payment rate will be set at the applicable statewide average per discharge rate (i.e. teaching with intern/resident program, teaching without intern/resident program, and non-teaching).

b. For freestanding long-term care psychiatric facilities, payment will be at the statewide average per diem for long term care psychiatric facilities plus projected capital and medical education costs as applicable.

c. For Residential Treatment Facilities, payments will be based on a statewide average of all the RTF rates.

I. Retrospective Hospital Cost Settlements

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

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

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

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

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

1. Qualifying Criteria. All non-state government operated hospitals in South Carolina that meet all of the following criteria as of the approval date of the State Plan Amendment implementing this Section (Transmittal Number 11-022) qualify for payments under this Section N:

   a. The hospitals are part of a hospital system in South Carolina;

      i. A hospital system is defined as two or more hospitals (as determined based on independent Medicaid provider numbers) located in South Carolina that share common ownership.

   b. At least one hospital in the hospital system must be designated as a Trauma I or Trauma II hospital by the South Carolina Department of Health and Environmental Control;

   c. All hospitals in the hospital system must be operated by a regional health service district in accordance with Sections 44-7-2150 through 44-7-2157 of the South Carolina Code of Laws;

   d. At least one hospital in the hospital system must be designated as a Regional Perinatal Center by the South Carolina Department of Health and Environmental Control; and

   e. At least one hospital in the hospital system must be located in a small urban county.

      i. A small urban county is defined as a county in South Carolina with a population less than three-hundred and fifty thousand (350,000) residents, as measured by the U.S. Census Bureau's 2010 Decennial Census, which is designated as an urban county based on the hospital's Core Based Statistical Area in the Centers for Medicare and Medicaid Services' May 2013 Public Use File.

2. Reimbursement Methodology. Each qualifying hospital shall receive quarterly supplemental enhanced payments for the inpatient

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

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

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

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

3. UPL Calculation for Supplemental Enhanced Payment

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

The most recent HFY 2012 2552-10 cost report serves as the base year cost report used to establish the maximum supplemental enhanced payments. In order to determine the maximum payments available, the following methodology is employed:

(1) The inpatient hospital routine and ancillary cost is determined as follows: Medicaid inpatient routine cost is determined by multiplying Medicaid covered days from the SC MMIS and reconciled to worksheet S-3, Part I, column 7, Lines 1, 8 through 13 and 16 through 17 by the routine cost per diems determined by the amounts reflected on worksheet B, Part I, column 24, lines 30 through 43 divided by total days of each routine cost center reflected on worksheet S-3, column 8, lines 1 through 18. Medicaid inpatient hospital ancillary cost is determined by multiplying covered Medicaid inpatient hospital covered ancillary charges reconciled to the SC MMIS and identified on the Medicaid worksheet D-3, column 2, lines 50 through 112 by the ancillary cost to charge ratios as reflected on worksheet C, column 9, lines 50 through 112. Any ancillary services reflected within these lines (i.e. 50 through 112)

that are not considered an inpatient or outpatient hospital service (e.g. home health, ambulance, etc.) will not be reflected within these calculations.

(2) Covered Medicaid inpatient hospital days used in the UPL calculation are reconciled to the SC MMIS.

(3) Covered Medicaid inpatient hospital ancillary charges used in the UPL calculations are those that are provider reported and are subject to reconciliation to the SC MMIS if a variance of 3%+ exists between provider reported inpatient ancillary charges versus SC MMIS reported inpatient ancillary charges.

(4) To determine the UPL gap that will be used to make supplemental payments the amount determined for each hospital in step 1 above will be subtracted from the amount paid to each hospital adjusted for any changes in payment rates during the payment year. The aggregate gap amount for each group of hospitals (private and non-state government) will serve as the basis for the supplemental payments to the private and non-state government hospitals. Furthermore, the supplemental payments available under this section cannot exceed the difference between total Medicaid covered inpatient hospital charges and total allowable Medicaid inpatient revenue received by each hospital eligible to receive UPL reimbursement under this section.

(5) For payments made on and after October 1, 2012, base year cost will be trended accordingly using CMS Market Basket rates and Medicaid base year revenue will be adjusted accordingly to reflect changes made to SC Medicaid inpatient hospital reimbursement since October 1, 2012. For subsequent fiscal years, data utilized from the HFY 2552-10 cost report and HFY Summary MARS Report will be no older than 2 years prior to the projected spending year.

O. Supplemental Enhanced Payment for Qualifying Private Hospitals

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

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

1. Qualifying Criteria. All private hospitals in South Carolina that meet all of the following criteria as of the approval date of the State Plan Amendment implementing this Section (Transmittal Number 11-022) qualify for supplemental payments under this Section O:

   a. The hospitals are part of a hospital system in South Carolina;

      i. A hospital system is defined as two or more hospitals (as determined based on independent Medicaid provider numbers) located in South Carolina that share common ownership.

   b. At least one hospital in the hospital system must be designated as a Trauma I or Trauma II hospital by the South Carolina Department of Health and Environmental Control;

   c. All hospitals in the hospital system must be recognized as a Joint Commission Top Performer for at least three Key Quality Measures, as reflected in the 2012 report from The Joint Commission;

   d. At least one hospital in the hospital system must have an Advanced Certification as a Primary Stroke Center from The Joint Commission;

   e. At least one hospital in the hospital system must be a large rural hospital; and

      i. A large rural hospital is defined as a hospital that both has an average daily census of greater than fifty (50), according to the Centers for Medicare and Medicaid Services' May 2013 Public Use File, and is located in a county with a population of less than sixty thousand (60,000) as measured by the U.S. Census Bureau's 2010 Decennial Census.

   f. At least one hospital in the hospital system must be located in a small urban county.

      i. A small urban county is defined as a county in South Carolina with a population less than three-hundred and

fifty thousand (350,000) residents, as measured by the U.S. Census Bureau's 2010 Decennial Census, which is designated as an urban county based on the hospital's Core Based Statistical Area in the Centers for Medicare and Medicaid May 2013 Public Use File.

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

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

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

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

3. UPL Calculation for Supplemental Enhanced Payment

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

The most recent HFY 2012 2552-10 cost report serves as the base year cost report used to establish the maximum supplemental enhanced payments. In order to determine the maximum payments available, the following methodology is employed:

(1) The inpatient hospital routine and ancillary cost is determined as follows: Medicaid inpatient routine cost is determined by multiplying Medicaid covered days from the SC MMIS and reconciled to worksheet S-3, Part I, column 7, Lines 1, 8 through 13 and 16 through 17 by the routine cost per diems determined by the amounts reflected on worksheet B, Part I, column 24, lines 30 through 43 divided by total days of each routine cost center reflected on worksheet S-3, column 8, lines 1 through 18. Medicaid inpatient hospital ancillary cost is determined by multiplying covered Medicaid inpatient hospital covered ancillary charges reconciled to the SC MMIS and identified on

the Medicaid worksheet D-3, column 2, lines 50 through 112 by the ancillary cost to charge ratios as reflected on worksheet C, column 9, lines 50 through 112. Any ancillary services reflected within these lines (i.e. 50 through 112) that are not considered an inpatient or outpatient hospital service (e.g. home health, ambulance, etc.) will not be reflected within these calculations.

(2) Covered Medicaid inpatient hospital days used in the UPL calculation are reconciled to the SC MMIS.

(3) Covered Medicaid inpatient hospital ancillary charges used in the UPL calculations are those that are provider reported and are subject to reconciliation to the SC MMIS if a variance of 3%+ exists between provider reported inpatient ancillary charges versus SC MMIS reported inpatient ancillary charges.

(4) To determine the UPL gap that will be used to make supplemental payments the amount determined for each hospital in step 1 above will be subtracted from the amount paid to each hospital adjusted for any changes in payment rates during the payment year. The aggregate gap amount for each group of hospitals (private and non-state government) will serve as the basis for the supplemental payments to the private and non-state government hospitals. Furthermore, the supplemental payments available under this section cannot exceed the difference between total Medicaid covered inpatient hospital charges and total allowable Medicaid inpatient revenue received by each hospital eligible to receive UPL reimbursement under this section.

(5) For payments made on and after October 1, 2012, base year cost will be trended accordingly using CMS Market Basket rates and Medicaid base year revenue will be adjusted accordingly to reflect changes made to SC Medicaid inpatient hospital reimbursement since October 1, 2012. For subsequent fiscal years, data utilized from the HFY 2552-10 cost report and HFY Summary MARS Report will be no older than 2 years prior to the projected spending year.

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

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

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
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Baltimore, MD 21244-1850

CMS
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CENTER FOR MEDICAID & CHIP SERVICES

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OCT 10 2014

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If you have any questions, please call Stanley Fields at (502) 223-5332.

Sincerely,

Timothy Hill
Director

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: SC 11-022

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
10/01/11

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)*

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See changes in box 23

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14. TITLE:
Director

15. DATE SUBMITTED:
October 28, 2011

16. RETURN TO:

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

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: OCT 10 2014

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: OCT 01 2011

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: Kristin Fan

22. TITLE: Deputy Director, FMG

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Pen & Ink authorized changes to the 179

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I. Retrospective Hospital Cost Settlements

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

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

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

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

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

1. Qualifying Criteria. All non-state government operated hospitals in South Carolina that meet all of the following criteria as of the approval date of the State Plan Amendment implementing this Section (Transmittal Number 11-022) qualify for payments under this Section N:

   a. The hospitals are part of a hospital system in South Carolina;

      i. A hospital system is defined as two or more hospitals (as determined based on independent Medicaid provider numbers) located in South Carolina that share common ownership.

   b. At least one hospital in the hospital system must be designated as a Trauma I or Trauma II hospital by the South Carolina Department of Health and Environmental Control;

   c. All hospitals in the hospital system must be operated by a regional health service district in accordance with Sections 44-7-2150 through 44-7-2157 of the South Carolina Code of Laws;

   d. At least one hospital in the hospital system must be designated as a Regional Perinatal Center by the South Carolina Department of Health and Environmental Control; and

   e. At least one hospital in the hospital system must be located in a small urban county.

      i. A small urban county is defined as a county in South Carolina with a population less than three-hundred and fifty thousand (350,000) residents, as measured by the U.S. Census Bureau's 2010 Decennial Census, which is designated as an urban county based on the hospital's Core Based Statistical Area in the Centers for Medicare and Medicaid Services' May 2013 Public Use File.

2. Reimbursement Methodology. Each qualifying hospital shall receive quarterly supplemental enhanced payments for the inpatient

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

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

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

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

3. UPL Calculation for Supplemental Enhanced Payment

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

The most recent HFY 2012 2552-10 cost report serves as the base year cost report used to establish the maximum supplemental enhanced payments. In order to determine the maximum payments available, the following methodology is employed:

(1) The inpatient hospital routine and ancillary cost is determined as follows: Medicaid inpatient routine cost is determined by multiplying Medicaid covered days from the SC MMIS and reconciled to worksheet S-3, Part I, column 7, Lines 1, 8 through 13 and 16 through 17 by the routine cost per diems determined by the amounts reflected on worksheet B, Part I, column 24, lines 30 through 43 divided by total days of each routine cost center reflected on worksheet S-3, column 8, lines 1 through 18. Medicaid inpatient hospital ancillary cost is determined by multiplying covered Medicaid inpatient hospital covered ancillary charges reconciled to the SC MMIS and identified on the Medicaid worksheet D-3, column 2, lines 50 through 112 by the ancillary cost to charge ratios as reflected on worksheet C, column 9, lines 50 through 112. Any ancillary services reflected within these lines (i.e. 50 through 112)

that are not considered an inpatient or outpatient hospital service (e.g. home health, ambulance, etc.) will not be reflected within these calculations.

(2) Covered Medicaid inpatient hospital days used in the UPL calculation are reconciled to the SC MMIS.

(3) Covered Medicaid inpatient hospital ancillary charges used in the UPL calculations are those that are provider reported and are subject to reconciliation to the SC MMIS if a variance of 3%+ exists between provider reported inpatient ancillary charges versus SC MMIS reported inpatient ancillary charges.

(4) To determine the UPL gap that will be used to make supplemental payments the amount determined for each hospital in step 1 above will be subtracted from the amount paid to each hospital adjusted for any changes in payment rates during the payment year. The aggregate gap amount for each group of hospitals (private and non-state government) will serve as the basis for the supplemental payments to the private and non-state government hospitals. Furthermore, the supplemental payments available under this section cannot exceed the difference between total Medicaid covered inpatient hospital charges and total allowable Medicaid inpatient revenue received by each hospital eligible to receive UPL reimbursement under this section.

(5) For payments made on and after October 1, 2012, base year cost will be trended accordingly using CMS Market Basket rates and Medicaid base year revenue will be adjusted accordingly to reflect changes made to SC Medicaid inpatient hospital reimbursement since October 1, 2012. For subsequent fiscal years, data utilized from the HFY 2552-10 cost report and HFY Summary MARS Report will be no older than 2 years prior to the projected spending year.

O. Supplemental Enhanced Payment for Qualifying Private Hospitals

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

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

1. Qualifying Criteria. All private hospitals in South Carolina that meet all of the following criteria as of the approval date of the State Plan Amendment implementing this Section (Transmittal Number 11-022) qualify for supplemental payments under this Section O:

   a. The hospitals are part of a hospital system in South Carolina;

      i. A hospital system is defined as two or more hospitals (as determined based on independent Medicaid provider numbers) located in South Carolina that share common ownership.

   b. At least one hospital in the hospital system must be designated as a Trauma I or Trauma II hospital by the South Carolina Department of Health and Environmental Control;

   c. All hospitals in the hospital system must be recognized as a Joint Commission Top Performer for at least three Key Quality Measures, as reflected in the 2012 report from The Joint Commission;

   d. At least one hospital in the hospital system must have an Advanced Certification as a Primary Stroke Center from The Joint Commission;

   e. At least one hospital in the hospital system must be a large rural hospital; and

      i. A large rural hospital is defined as a hospital that both has an average daily census of greater than fifty (50), according to the Centers for Medicare and Medicaid Services' May 2013 Public Use File, and is located in a county with a population of less than sixty thousand (60,000) as measured by the U.S. Census Bureau's 2010 Decennial Census.

   f. At least one hospital in the hospital system must be located in a small urban county.

      i. A small urban county is defined as a county in South Carolina with a population less than three-hundred and

fifty thousand (350,000) residents, as measured by the U.S. Census Bureau's 2010 Decennial Census, which is designated as an urban county based on the hospital's Core Based Statistical Area in the Centers for Medicare and Medicaid May 2013 Public Use File.

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

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

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

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

3. UPL Calculation for Supplemental Enhanced Payment

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

The most recent HFY 2012 2552-10 cost report serves as the base year cost report used to establish the maximum supplemental enhanced payments. In order to determine the maximum payments available, the following methodology is employed:

(1) The inpatient hospital routine and ancillary cost is determined as follows: Medicaid inpatient routine cost is determined by multiplying Medicaid covered days from the SC MMIS and reconciled to worksheet S-3, Part I, column 7, Lines 1, 8 through 13 and 16 through 17 by the routine cost per diems determined by the amounts reflected on worksheet B, Part I, column 24, lines 30 through 43 divided by total days of each routine cost center reflected on worksheet S-3, column 8, lines 1 through 18. Medicaid inpatient hospital ancillary cost is determined by multiplying covered Medicaid inpatient hospital covered ancillary charges reconciled to the SC MMIS and identified on

the Medicaid worksheet D-3, column 2, lines 50 through 112 by the ancillary cost to charge ratios as reflected on worksheet C, column 9, lines 50 through 112. Any ancillary services reflected within these lines (i.e. 50 through 112) that are not considered an inpatient or outpatient hospital service (e.g. home health, ambulance, etc.) will not be reflected within these calculations.

(2) Covered Medicaid inpatient hospital days used in the UPL calculation are reconciled to the SC MMIS.

(3) Covered Medicaid inpatient hospital ancillary charges used in the UPL calculations are those that are provider reported and are subject to reconciliation to the SC MMIS if a variance of 3%+ exists between provider reported inpatient ancillary charges versus SC MMIS reported inpatient ancillary charges.

(4) To determine the UPL gap that will be used to make supplemental payments the amount determined for each hospital in step 1 above will be subtracted from the amount paid to each hospital adjusted for any changes in payment rates during the payment year. The aggregate gap amount for each group of hospitals (private and non-state government) will serve as the basis for the supplemental payments to the private and non-state government hospitals. Furthermore, the supplemental payments available under this section cannot exceed the difference between total Medicaid covered inpatient hospital charges and total allowable Medicaid inpatient revenue received by each hospital eligible to receive UPL reimbursement under this section.

(5) For payments made on and after October 1, 2012, base year cost will be trended accordingly using CMS Market Basket rates and Medicaid base year revenue will be adjusted accordingly to reflect changes made to SC Medicaid inpatient hospital reimbursement since October 1, 2012. For subsequent fiscal years, data utilized from the HFY 2552-10 cost report and HFY Summary MARS Report will be no older than 2 years prior to the projected spending year.

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

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

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