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State/Territory Name: South Carolina

State Plan Amendment (SPA) #: 25-0006

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form/Summary Form (with 179-like data)
3) Approved SPA Pages

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

Financial Management Group

June 17, 2026

Eunice Medina
Interim Director, Department of Health & Human Services
Post Office Box 8206
1801 Main Street
Columbia, SC 29202-8206

RE: TN SC-25-0006

Dear Director Medina:

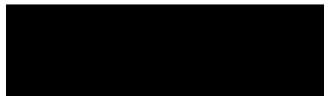
The Centers for Medicare & Medicaid Services (CMS) has reviewed the proposed South Carolina state plan amendment (SPA) to Attachment 4.19-A SC-25-0006, which was submitted to CMS on December 29, 2025. This plan amendment updates the classification system used to reimburse inpatient hospital services from version 32 of the Solventum (formerly 3M) All Patient Refined Diagnosis Related Groups (APR-DRGs) classification system to version 42 of the APR-DRGs classification system.

We reviewed your SPA submission for compliance with statutory requirements, including in sections 1902(a)(2), 1902(a)(13), 1902(a)(30), and 1903 as it relates to the identification of an adequate source for the non-federal share of expenditures under the plan, as required by 1902(a)(2) of the Social Security Act and the applicable implementing Federal regulations.

Based upon the information provided by the state, we have approved the amendment with an effective date of October 1, 2025. We are enclosing the approved CMS-179 and a copy of the new state plan pages.

If you have any additional questions or need further assistance, please contact James Francis at 617-531-7575 or via email at James.Francis@cms.hhs.gov.

Sincerely,



Rory Howe
Director
Financial Management Group

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 2 5 — 0 0 0 6

2. STATE: S C

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

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: October 1, 2025

5. FEDERAL STATUTE/REGULATION CITATION
42 CFR Part 447, Subpart C, 1902(a)(13) of the Act

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2026 $ 0
b. FFY 2027 $ 0

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
~~Attachment 4.19-A, pages 1, 2b, 3, 4, 10, 11, 14, 15,16, 19, 20, 23~~
Attachment 4.19-A, pages 1, 2b, 3, 4, 6, 10, 11, 12, 14, 15, 16, 19, 20, 23

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
~~Attachment 4.19-A, pages 1, 2b, 3, 4, 10, 11, 14, 15, 16, 19, 20, 23~~
Attachment 4.19-A, pages 1, 2b, 3, 4, 6, 10, 11, 12, 14, 15, 16, 19, 20, 23

9. SUBJECT OF AMENDMENT
Inpatient hospital APR-DRG update from Version 32 to Version 42 effective 10-1-25.

10. 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:
Ms. Medina was designated by the Governor to review and approve all State Plans.

11. SIGNATURE OF STATE AGENCY OFFICIAL

12. TYPED NAME
Eunice Medina

13. TITLE
Director

14. DATE SUBMITTED
December 29, 2025

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

FOR CMS USE ONLY

16. DATE RECEIVED
December 29, 2025

17. DATE APPROVED

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
October 1, 2025

19. SIGNATURE OF APPROVING OFFICIAL

20. TYPED NAME OF APPROVING OFFICIAL
Rory Howe

21. TITLE OF APPROVING OFFICIAL
Director, Financial Management Group

22. REMARKS
4/30/26: South Carolina requested a pen-and-ink change to Blocks 7 and 8 to add pages 6 and 12 to the list of pages. (JGF)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF SOUTH CAROLINA

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

I. General Provisions

A. Purpose

This plan establishes:

1. a retrospective reimbursement system for qualifying burn intensive care unit hospitals as defined in the plan.

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

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

4. An all-inclusive per diem reimbursement system for pediatric inpatient rehabilitation units or facilities.

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

B. Objectives

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

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

C. Overview of Reimbursement Principles

1. The South Carolina Medicaid Program will reimburse qualified providers for inpatient institutional services using one or more of the following methods effective for discharges occurring on or after October 1, 2025:

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

b. Prospective payment rates will be reimbursed to free standing short term psychiatric hospitals that contract with the SC Medicaid Program for the first time or reenter the SC Medicaid Program effective on or after July 1, 2014 via a statewide free standing short term psychiatric hospital statewide average rate. Effective July 1, 2024, free standing short term psychiatric hospitals that contract with the SC Medicaid Program will be reimbursed a per diem of $800 per member per day. This per diem is set at 89% of the 2024 Medicare Inpatient Psychiatric Facilities rate.

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 65th 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 15th percentile of the October 1, 2014 base rate component, these hospitals will be reimbursed at the 15th percentile base rate component. However, any teaching hospital with a medical education add-on and whose base rate component falls below the 15th 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 15th 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 65th percentile cap will be reimbursed the lower of allowable actual Medicaid reimbursable inpatient hospital costs or Medicaid inpatient hospital payments at 65th 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 and short-term psychiatric hospitals effective on or after July 1, 2024) 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.

5. Effective for discharges incurred on and after October 1, 2015, the Medicaid Agency will reimburse inpatient hospital services using version 32 of 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 acute care hospitals), short term psychiatric hospitals, and long term acute care hospitals. Version 32 of the APR-DRG grouper and corresponding national relative weights will be used effective October 1, 2015.

6. Effective for discharges incurred on and after October 1, 2025, the Medicaid Agency will reimburse inpatient hospital services using version 42 of 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 acute care hospitals) and long term acute care hospitals. Version 42 of the APR-DRG grouper and corresponding national relative weights will be used effective October 1, 2025.

7. An outlier set-aside adjustment (to cover outlier payments described in 11 of this section) will be made to the per discharge rates.

8. Payment for services provided in private freestanding long term care psychiatric facilities that contract with the SC Medicaid Program for the first time or reenter the SC Medicaid Program effective on and after November 1, 2013 shall be based on the provider’s desk reviewed cost report rate but cannot exceed the statewide average per diem rate of the governmental psychiatric long-term care providers in existence at the time the new private provider enters the Medicaid program.

9. Effective July 1, 2024, free standing short term psychiatric hospitals that contract with the SC Medicaid Program will be reimbursed a per diem of $800 per member per day. This per diem is set at 89% of the 2024 Medicare Inpatient Psychiatric Facilities rates.

10. The payments determined under both payment methods, the DRG payment system for general acute care hospitals, including acute psychiatric and rehabilitation units, and long term acute care hospitals and the per diem method for psychiatric long-term care facilities, and free standing short term care psychiatric hospitals will be adjusted to recognize facility specific costs associated with direct and indirect medical education , capital and ancillary services as appropriate. In addition to the claims payment, hospitals may receive other payments as outlined in this Attachment. Some examples are as follows: Section VI I describes hospital cost settlements and Section VII describes Disproportionate Share Hospital payments.

11. Special payment provisions, as provided in Section VI A of this plan, will be available under the DRG payment system for discharges which are atypical in terms of costs of services provided during the stay. These cases will be referred to as outliers. Special payment policies, as specified in Section VI B and C of this plan, will also be made for cases involving a transfer of a patient from one hospital to another, or a readmission of a patient following an earlier discharge. These provisions are not applicable to long-term psychiatric and RTF claims or to free standing short term care psychiatric hospitals effective July 1, 2024.

12. A rate reconsideration process will be available to hospitals that have higher costs as a result of conditions described in IX A of this plan.

13. Disproportionate share payments will be paid to qualifying hospitals in accordance with the requirements specified in Section VII of this plan.

14. Payment for services provided in psychiatric residential treatment facilities (PRTFs) will represent core facility services including room and board as well as psychological training, testing, and assessment services. All medically related ancillary services as well as the psychiatric pharmaceutical costs incurred by Medicaid recipients residing in PRTFs will not be the responsibility of the PRTF but will be billed by the ancillary service provider to the state Medicaid program.

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

16. Effective for dates of service on or after July 1, 2023, qualifying inpatient rehabilitation units or facilities will receive payment for pediatric inpatient rehabilitation services based on an all-inclusive per-diem methodology for facility charges. Professional services will be reimbursed separately.

17. Effective for dates of service on or after January 1, 2024, hospital-based crisis stabilization observation stays greater than 24 hours will be reimbursed at the 4.19B outpatient payment rate/methodology.

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. Audit Adjustment Factor – An adjustment factor used in the hospital specific Medicaid inpatient hospital rate setting process based upon the results of the HFY 2010 final audit report issued by the SC Medicaid audit contractor.

4. Base Year - The fiscal year used for calculation of payment rates. For the hospital specific inpatient payment rates effective on and after November 1, 2012, the base year shall be each facility's 2011 fiscal year. For the freestanding governmental long-term psychiatric hospital rates, the base year shall be each facility's 2010 (state owned governmental) or 2011 (non-state owned governmental) fiscal year. Effective for services incurred on or after November 1, 2013, the base year used to calculate each freestanding governmental long-term psychiatric hospital rate will be each facility’s 2012 fiscal year cost report.

5. 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.

6. Calibration Adjustment – An adjustment that is used in the Medicaid inpatient hospital rate setting process that takes into account changes in hospital specific cost and hospital case mix and has the effect of increasing or decreasing hospital specific per discharge rates. This factor is also referred to as a “Rate Adjustment Factor”.

7. 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.

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

9. Complex Care Services – Those services rendered to patients that meet the South Carolina level of care criteria for long term care and have multiple needs (i.e. two or more) which fall within the highest ranges of disabilities in the criteria.

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

In addition to the above criteria, hospitals must satisfy the next two criteria in order to qualify for the SC Medicaid DSH Program:

a. Hospitals must have a Medicaid day utilization percentage of at least one percent.

b. Hospitals must have at least two (2) obstetricians with staff privileges who have agreed to provide obstetrical services to Medicaid patients on a non-emergency basis. In the case of a hospital located in a rural area (as defined for purposes of section 1886 of the Social Security Act), the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures. This rule does not apply to a hospital that did not offer non-emergency obstetric services to the general population as of December 22, 1987.

Information pertaining to the base year(s) will be collected during the second and third quarter of the calendar year and will be used to determine which hospitals qualify for disproportionate share. Financial and statistical information used to determine disproportionate share qualification and payment will be submitted and/or verified on Medicaid supplemental worksheets. The supplemental worksheets must be completed correctly. Data will be verified by the DHHS using appropriate sources, including, but not limited to, the CMS 2552 and the DHHS inpatient MARS report and administrative days report. Disproportionate share eligibility does not qualify for the rate reconsideration process.

The disproportionate share payment methodology is set forth is Section VII A.

17. General Acute Care Hospital - An institution licensed as a hospital by the applicable South Carolina licensing authority and certified for participation in the Medicare (Title XVIII) program.

18. Geometric Mean – The measure of central tendency of a set of n values computed by extracting the nth root of the product of the values.

    Example: The geometric mean of 2, 4 and 1 is $\sqrt[3]{2x4x1 = 2}$

19. Indirect Medical Education Cost - Those indirect costs resulting from the additional tests and procedures performed on patients because the hospital is a teaching institution. Such costs are determined using the number of interns and residents per operating bed in a Federally derived indirect medical education equation.

20. Indirect Medical Education Percentage - The Medicare indirect medical education formula (adjusted to include psychiatric and rehab subprovider beds) is used to calculate indirect medical education cost. The formula used is as follows:

    1.35 x [(1 + (interns and residents)/beds)$^{.405)}$ - 1]

21. Inpatient - A patient who has been admitted to a medical facility on the recommendation of a physician or a dentist and who is receiving room, board and professional services in the facility. A patient who is admitted to an acute care facility and expires while in the facility shall be considered an inpatient admission regardless of whether the stay was overnight.

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.

3. Pediatric Inpatient Rehabilitation Units or Facilities

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

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

Computation of the October 1, 2025 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, hospital fiscal year (HFY) 2022 Medicaid inpatient cost to charge ratios (or other recent cost to charge ratios if HFY 2022 cost report information is unavailable) adjusted for applicable April 8, 2011 and July 11, 2011 reimbursement changes ("adjusted hospital specific cost to charge ratios"), July 1, 2023 through June 30, 2024 incurred inpatient hospital claims, July 1, 2025 inpatient hospital rates hospital specific add-ons, and case mix index.

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 hospital specific and/or statewide average per discharge rates. Effective for discharges incurred on or after October 1, 2025, the Medicaid Agency will determine inpatient hospital claim payments based upon the DRG listing contained within version 42 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, any new hospital assigned a hospital specific per discharge rate effective on or before July 1, 2025 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 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.

B. Allowable Inpatient Costs

For acute care and long term acute care hospital inpatient rates effective on and after November 1, 2012, allowable inpatient cost information of covered services from each hospital's FY 2011 cost report (adjusted for the impact of the HFY 2010 audit adjustment factor) will serve as the basis for computation of the hospital specific per discharge rate and the statewide average per discharge rate. All long term acute care and contracting SC acute care hospitals as well as out of state contracting border hospitals with SC Medicaid inpatient claim utilization of at least 10 claims and a S. C. Medicaid cost report were used in this analysis. The source document for Medicaid allowable inpatient costs will be the CMS-2552, which is the Medicare/Medicaid cost report. Allowable Medicaid inpatient costs will be determined in accordance with the Provider Reimbursement Manual Publication 15. However, no adjustment will be made to carve out the private room differential costs. For clarification purposes one hundred percent of the South Carolina general acute care hospital provider tax will be considered an allowable Medicaid cost. Medicare's recent policy change relating to the inclusion of Medicaid labor and delivery patient days in the Medicare Disproportionate Share calculation effective for cost reporting periods beginning on and after October 1, 2009 will have no impact on the calculation of allowable Medicaid inpatient hospital costs beginning on and after October 1, 2009. Hospitals will continue to determine patient days for maternity patients in accordance with the provisions of the Provider Reimbursement Manual HIM-15, section 2205.2. Inpatient 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 2011 SCDHHS MARS paid claims summary data report for each acute care hospital identified above will also be used during the analysis.

1. As filed total facility costs are identified from each facility's FY 2011 Worksheet B Part I (BI) CMS-2552 cost report. Total inpatient facility costs would include operating, capital, direct medical education, and indirect medical education costs. Swing bed and Administrative Day payments are deducted from the adult and pediatric cost center on the CMS-2552 as well as CRNA costs. Observation cost is reclassified.

2. As filed total facility costs will be allocated to Medicaid inpatient hospital cost using the following methods.

   a. 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 (as reported on Worksheet D-3 for Medicaid inpatient ancillary charges) to yield total SC Medicaid inpatient ancillary costs.

   b. SC Medicaid routine service costs will be computed by dividing each routine cost center by total patient days of the applicable routine cost center and then multiplying by the applicable SC Medicaid covered patient days. Total SC Medicaid routine costs will represent the accumulation of the SC Medicaid cost determined from each applicable routine cost center.

3. The SC Medicaid inpatient cost-to-charge ratio, which reflects 100% of allowable Medicaid costs (including DME and IME) will be determined by taking the sum of the SC Medicaid routine service costs and inpatient ancillary costs and dividing this amount by the sum of the SC Medicaid covered routine service charges and inpatient covered ancillary charges.

4. Next, for non teaching hospitals, the inpatient hospital cost to charge ratio as determined in step 3. above will be reduced by either the April 8, 2011 payment reduction amount (i.e.3% of all costs) or by the July 11, 2011 payment reduction amount (i.e. 7% of all costs) as defined under Section I. (C), Overview of Reimbursement Principles, paragraphs (1) b., c., d., and e.

5. Next, for teaching hospitals as defined by the state plan, the inpatient hospital cost to charge ratio as determined in step 3. above will need to be broken out into two inpatient hospital cost to charge ratios consisting of base operating costs (including capital) and Graduate Medical Education costs (including Direct and Indirect). Therefore, Direct Medical Education costs as reported on worksheet B Part I are identified and removed from total allowable facility costs as reported under worksheet B, Part I, column 24 to determine base operating costs. Next, to determine the amount of Indirect Medical Education costs of teaching hospitals with an intern and resident training program, the base operating costs previously described will be multiplied by the Indirect Medical Education formula described in Section II 20. The amount of Indirect Medical Education costs as determined in this computation will be removed from base operating costs and then added to the amount of Direct Medical Education costs to determine Graduate Medical Education costs. Next, routine per diems and ancillary cost to charge ratios will be developed for both base operating costs and Graduate Medical Education costs based upon the methodology previously described in this section and multiplied by covered Medicaid inpatient hospital days and covered Medicaid inpatient ancillary charges to determine two Medicaid cost pools – one for base operating costs and one for Graduate Medical Education costs. Next, in order to determine the Medicaid allowable inpatient hospital cost, the individual cost pools will be reduced by either the April 8, 2011 payment reduction amount (i.e. 3% of all costs) or by the July 11, 2011 payment reduction amount (i.e. 7% on base and 12.7% or 100% on Graduate Medical Education costs) as defined under Section I. (C), Overview of Reimbursement Principles, paragraphs (1) b., c., d., and e. Finally, the two adjusted Medicaid cost pools will be summed and divided by total Medicaid inpatient hospital covered charges to determine the Medicaid inpatient hospital cost to charge ratio for use in the November 1, 2012 rate setting prior to the application of the HFY 2010 audit adjustment factor.

6. Finally, cost to charge ratios determined in steps 4 and 5 will be adjusted upward or downward by the HFY 2010 audit adjustment factor. The HFY 2010 audit adjustment factor is determined by taking the audited HFY 2010 inpatient cost to charge ratio and dividing it by the interim HFY 2010 inpatient cost to charge ratio.

In a separate computation, a cost per day will be determined for prospective reimbursement for all free-standing long-term care psychiatric facilities based on 2010 or 2011 cost report data for services provided on or after October 1, 2012. Effective for services incurred on or after November 1, 2013, the base year used to calculate each freestanding governmental long-term psychiatric hospital rate will be each facility’s 2012 fiscal year.

D. DRG Relative Weights

The relative weights used for calculating reimbursement for hospitals paid under the DRG payment system will be the corresponding national relative weights of version 42 of the APR-DRG grouper. Relative weights will be reviewed annually and updated as needed at the same time as the DRG grouper is updated.

E. Medicaid Case-Mix Index

A case-mix index, which is a relative measure of a hospital's resource use, will be used to adjust the per discharge cost amounts to the statewide average case-mix. For each hospital the per discharge case-mix index will be computed by multiplying the number of incurred SC Medicaid inpatient claims during the period July 1, 2023 through June 30, 2024 by the DRG relative weight, summing these amounts and dividing by the sum of the total per case discharges. Version 42 of the APR-DRG grouper and the corresponding national relative weights were used in the calculation of the case mix index for each hospital.

V. Reimbursement Rates

A. Inpatient Hospital

The computation of the hybrid payment system rates will require two distinct methods - one for computation of the hospital specific per discharge rates, and a second for computation of per diem rates for freestanding long-term care psychiatric facilities, freestanding short term psychiatric hospitals, psychiatric residential treatment facilities and pediatric inpatient rehabilitation units or facilities.

1. Hospital Specific Per Discharge Rates Effective October 1, 2025:

The following methodology is employed in the computation of the hospital specific per discharge rates effective October 1, 2025:

a. First, the July 1, 2025 hospital specific per discharge rates under version 32 of the APR-DRG grouper were adjusted to remove the Graduate Medical Education (Direct Medical Education and Indirect Medical Education) rate components of the hospital specific per discharge rates.

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, 2023 through June 30, 2024 period against its July 1, 2025 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, 2023 through June 30, 2024 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, 2023 through June 30, 2024, equaled each hospital's specific baseline expenditure target.

1. DRGs as defined by version 42 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. 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;

d. Next, once each teaching hospital's specific base rate was determined in accordance with step c above, the Direct Medical Education (DME) and Indirect Medical education (IME) components for each hospital was developed by taking the hospital specific DME and IME components for each hospital as of July 1, 2025 under Version 32 of the APR-DRG grouper and multiplying by the change in the base rate from Version 32 to Version 42 of the APR-DRG grouper and making any additional adjustments needed to achieve budget neutrality for each hospital. These components were then added to the hospital specific base rate to develop the hospital specific per discharge rate.

e. For all other hospitals that did not receive a hospital specific per discharge rate, a statewide per discharge rate was calculated to achieve a budget neutral effect relative to the version 32 APR-DRG based payment system for hospitals that are paid using a statewide DRG base rate as of July 1, 2025.

f. The rates described in d and e above are then multiplied by the relative weight for that DRG to calculate the reimbursement for each DRG claim.

VI. Special Payment Provisions

A. Payment for Outlier Cases – Per Discharge DRG Cases

1. Payments in addition to the base DRG reimbursement are available to a facility for covered inpatient services provided to a Medicaid recipient if the following conditions are met.

a. The hospital's adjusted cost for a claim exceeds the sum of the DRG threshold and DRG reimbursement. For hospitals which receive its own hospital specific per discharge rate, the hospital's adjusted cost is derived by applying the adjusted hospital specific cost to charge ratio described in Section V. For hospitals that receive the statewide average per discharge rate, the hospital's adjusted cost is derived by applying the adjusted statewide cost to charge ratio of 0.3050 effective October 1, 2025.

b. The cost outlier thresholds were calculated using the following methodology:

- For each DRG and severity of illness (SOI) combination, 2 standard deviations of untrimmed charges from the Solventum™ version 42 APR DRG HSRV relative weights data file was calculated as the initial outlier threshold. For 4 base DRG and SOI combinations for which the Solventum™ relative weight file did not provide this information, 2 standard deviations of charges from an adjacent SOI for the same base DRG was assigned as the initial outlier threshold.

- To update the version 32 APR DRG payment system minimum and maximum outlier thresholds of $33,000 and $98,000, 10 years of trend was applied to estimate version 42 payment system minimum and maximum outlier threshold values of $44,000 and $132,000, respectively.

- Applying an adjustment factor of 0.1750 to the 2 standard deviations of untrimmed charges and the minimum and maximum outlier threshold values of $44,000 and $132,000, DRG outlier thresholds for each DRG and SOI combination under version 42 APR DRGs were calculated to achieve the same simulated aggregate percentage of outlier payments relative to total simulated DRG payments between the version 32 and version 42 APR DRG payment systems, on incurred inpatient hospital claims for the July 1, 2023 through June 30, 2024 period.

2. Additional payments for cases meeting the conditions in 1a above (cost outliers) will be made as follows:

   a. If the hospital discharge includes cost beyond the sum of the threshold and the DRG payment for the applicable DRG, an additional payment will be made to the provider for those costs. A special request by the hospital is not required in order to initiate this payment.

   b. Charges for any services identified through utilization review as non-covered services, will be denied and any outlier payment made for these services will be recovered.

   c. The additional payment amount for cost outlier shall be derived by multiplying 60% of the difference between the hospital's adjusted cost for the discharge less the threshold described in 1 b of this section less the DRG payment amount. The hospital's total payment for the case will be the DRG rate specified in Section V plus the outlier payment as described in this section.

B. Payment for Transfers

   1. Special payment provisions will apply when a patient has been transferred from one hospital to another.

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, 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 unless the hospital was assigned a hospital specific per discharge rate on or before October 1, 2025.

b. For private freestanding long-term care psychiatric facilities, payment will be at the statewide average per diem for long term care psychiatric facilities.

C. For freestanding short term psychiatric facilities, payment will be at the $800 per diem for short term psychiatric facilities.

d. For Psychiatric Residential Treatment Facilities (PRTFs), payment for services incurred on and after July 1, 2024, will be at the $525 per diem for all contracting privately owned and non-state owned governmental PRTF providers. The Medicaid Agency will reimburse all PRTF providers that provide services in private, non-state owned governmental, and state owned governmental SCDHHS-designated ASD PRTFs $788 per day for services incurred on or after July 1, 2024.

I. Retrospective Hospital Cost Settlements

Effective for services provided on or after October 1, 2014, 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.