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State/Territory Name: South Carolina

State Plan Amendment (SPA) #: 21-0013

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 S3-14-28
Baltimore, Maryland 21244-1850



Financial Management Group

November 8, 2021

Robert M. Kerr, Director
Department of Health & Human Services
1801 Main Street
Columbia, SC 29201

Reference: TN 21-0013

Dear Mr. Kerr:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 21-0013. This amendment updates the non-state-owned governmental Medicaid nursing facility rates based upon the most recent cost report information available based upon the use of the pre-COVID-19 reimbursement methodology in effect on October 1, 2019. Also, this plan amendment will update the state-owned governmental Medicaid nursing facility rates based upon the most recent cost report information available and updated trend factor.

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

This is to inform you that Medicaid State plan amendment SC-21-0013 is approved effective October 1, 2021. The CMS-179 and the plan pages are attached.

If you have any additional questions or need further assistance, please contact James Francis at james.francis@cms.hhs.gov.

Sincerely,

A solid black rectangular box redacting the signature of the sender.

For
Rory Howe
Director

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL		1. TRANSMITTAL NUMBER: 21-0013	2. STATE South Carolina
		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES		4. PROPOSED EFFECTIVE DATE October 1, 2021	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE & MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES			
5. TYPE OF PLAN MATERIAL (Check One):			
<input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> 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 (Part 447.250)		7. FEDERAL BUDGET IMPACT: a. FFY 2022 \$4,952,500 (\$7,000,000) x 70.75% b. FFY 2023 \$4,952,500 (\$7,000,000) x 70.75%	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-D pages, 5, 11, 12, 12a, 13, 14, 15, 17, 23, 26, 26a, 26b, 26c, 27, 32, 34, and 41 (New Page)		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Attachment 4.19-D pages, 5, 11, 12, 12a, 13, 14, 15, 17, 23, 26, 26a, 26b, 26c, 27, 32, and 34 (Attachment 4.19-D pages 11a and 17a will be deleted from the State Plan due to a language shift)	
10. SUBJECT OF AMENDMENT: This plan amendment will update the non-state-owned governmental Medicaid nursing facility rates based upon the most recent cost report information available based upon the use of the pre COVID-19 reimbursement methodology in effect on October 1, 2019. Also, this plan amendment will update the state-owned governmental Medicaid nursing facility rates based upon the most recent cost report information available and updated trend factor.			
11. GOVERNOR'S REVIEW (Check One):			
<input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL		<input checked="" type="checkbox"/> OTHER, AS SPECIFIED: Mr. Kerr was designated by the Governor to review and approval all State Plans.	
12. AGENCY OFFICIAL:		16. RETURN TO:	
<div style="background-color: black; width: 100px; height: 15px;"></div>		South Carolina Department of Health and Human Services Post Office Box 8206 Columbia, SC 29202-8206	
13. TYPED NAME: Robert M. Kerr			
14. TITLE: Acting Director			
15. DATE SUBMITTED: August 13, 2021			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED: 08/13/2021		18. DATE APPROVED: November 8, 2021	
PLAN APPROVED – ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: 10/01/2021		20. SIGNATURE OF REGIONAL OFFICIAL:	
<div style="background-color: black; width: 100%; height: 15px;"></div>			
21. TYPED NAME: Rory Howe		22. TITLE: Director	
23. REMARKS: Block 2 updated 11/03/2021 with authorization from state, adding state name "South Carolina."			

- (2) Calculation of FRV Capital Per Diem Rate - The new value construction cost per square foot shall be established at \$215.55 prior to the Location Factor adjustment. For the FRV Capital Per Diem rate effective October 1, 2019 and annually thereafter, the new construction cost of \$215.55 per square foot will be trended forward based on the historical cost index factor each October 1st as published annually in the RSMeans Construction Cost Data publication (October 1st, current year divided by October 1st, previous year). Effective October 1, 2021 the adjusted new construction cost per square foot will amount to \$231.11. The standard square footage minimum and maximums per age group per bed, the \$7,000 addition per Medicaid certified bed for equipment, and the 7.50% land value to be added to the fixed capital replacement was established in partnership with the state's nursing facility industry. The FRV Capital Per Diem rate is calculated as follows:
- a) First, determine the square footage that will be used in the computation. The square footage that will be used will be the greater of the actual measured gross square footage or the square footage determined by multiplying the number of Medicaid certified beds by the minimum square footage amount per room of 275. However in no event can the square footage used in the payment calculation exceed the maximum square footage ceiling amount per age group multiplied by the number of Medicaid certified beds. For clarification purposes, nursing facilities are allowed to include the square footage related to other facilities on the campus that are used to provide patient care related services such as kitchen or laundry facilities. However, the square footage of "out buildings" used for storage purposes cannot be included. In the event that a nursing facility fails to provide its required square footage data, the Medicaid Agency will determine the square footage at the minimum square footage allowance per bed along with the use of a thirty (30) year life.
 - b) Next, to determine the New Building Value Cost, first multiply the square footage determined in step a) above by \$231.11. To account for the Location Factor of each NF, apply the location factor as provided in the 2021 RSMeans Construction Cost Data publication against the amount calculated above. Location Factors are determined by the state in which the NF is located and the first three digits of the NF's zip code. The Location Factors will be updated annually based upon the base year cost reporting period FYE date.
 - c) Next, to determine the Moveable Equipment Replacement Value, multiply the number of Medicaid certified beds for each NF by \$7,000. Add this calculated amount to the New Building Value Cost as determined in step b) above to arrive at the Building and Equipment Replacement Value for each NF.

A. REIMBURSEMENT METHODOLOGY TO BE USED IN THE CALCULATION OF THE
MEDICAID REIMBURSEMENT RATES

A prospective rate shall be established for each nursing facility separately based on the facility's cost report, and upon the standard costs which are developed in accordance with the methodology described below. In the event that audit adjustments are made to cost reports in accordance with Title XIX and Title XVIII Program rules, regulations, policies and procedures, the rate of payment will be established so as to be consistent with the facility's cost as audited. In the event that such adjustment is made subsequent to the date that a facility was paid an incorrect rate based on unaudited costs, the facility will be liable to repay to the South Carolina Department of Health and Human Services the difference between the audited rate and the interim rate for the contract period. In a case in which an audited rate exceeds the interim rate, the South Carolina Department of Health and Human Services will be liable to repay the facility the difference between the audited rate and the interim rate for the contract periods beginning on or after October 1, 1994.

Effective October 1, 2010, nursing facilities which do not incur an annual Medicaid utilization in excess of 3,000 patient days will receive a prospective payment rate which will represent the weighted average industry rate at the beginning of each rate cycle. This rate will not be subject to change as a result of any field audit, but will be subject to change based on the lower of cost or charges test to ensure compliance with the state plan.

Minimum occupancy levels of 90% are currently being utilized for Medicaid rate setting purposes. For clarification purposes, nursing facility beds that are taken off-line due to renovation/construction issues relating to unsafe building conditions and considered unusable to meet the SC Department of Health and Environmental Control survey and certification guidelines will be temporarily excluded from the minimum occupancy computation for Medicaid rate setting purposes. Effective on and after October 1, 2013, Medicaid rates for nursing facilities located in counties where the county occupancy rate is less than 85% based upon the FYE September 30 cost report information will be established using the following policy:

- The SCDHHS will waive the 90% minimum occupancy requirement used for rate setting purposes for those nursing facilities located in counties whose occupancy is less than 85%. However, standards will remain at the 90% minimum occupancy level.
- The SCDHHS will calculate the affected nursing facilities' Medicaid reimbursement rate based upon the greater of the nursing facility's actual occupancy or the average of the county where the nursing facility is located. However, the SCDHHS will not participate in establishing payment rates using an occupancy rate of less than eighty-five percent (85%).

PROVIDER NAME: 0
PROVIDER NUMBER: 0
REPORTING PERIOD: 10/01/19 through 09/30/20 DATE EFF. 10/1/2021

PATIENT DAYS USED: 0 MAXIMUM BED DAYS:(less Complex Care) 0
TOTAL PROVIDER BEDS: 0 PATIENT DAYS INCURRED: 0
% Skilled 0.000 ACTUAL OCCUPANCY %: 0.00%
0.000 PATIENT DAYS @ 0.00% 0

COMPUTATION OF REIMBURSEMENT RATE - PERCENT SKILLED METHODOLOGY

	PROFIT INCENTIVE	TOTAL ALLOW COST	COST STANDARD	COMPUTED RATE
COSTS SUBJECT TO STANDARDS:				
GENERAL SERVICE		0.00	0.00	
DIETARY		0.00	0.00	
LAUNDRY/HOUSEKEEPING/MAINT.		0.00	0.00	
SUBTOTAL	0.00	0.00	0.00	0.00
ADMIN & MED REC	0.00	0.00	0.00	0.00
SUBTOTAL	0.00	0.00	0.00	0.00
COSTS NOT SUBJECT TO STANDARDS:				
UTILITIES		0.00		0.00
SPECIAL SERVICES		0.00		0.00
MEDICAL SUPPLIES AND OXYGEN		0.00		0.00
TAXES AND INSURANCE		0.00		0.00
LEGAL COST		0.00		0.00
SUBTOTAL		0.00		0.00
GRAND TOTAL		0.00		0.00
INFLATION FACTOR	3.50%			0.00
COST OF CAPITAL				0.00
PROFIT INCENTIVE (MAX 3.5% OF ALLOWABLE COST)			3.50%	0.00
COST INCENTIVE - FOR GENERAL SERVICE, DIETARY, LHM				0.00
EFFECT OF CAP ON COST/PROFIT INCENTIVES			\$1.75	0.00
SUBTOTAL				0.00
NON-EMERGENCY MEDICAL TRANSPORTATION (NEMT) ADD-ON				0.00
REIMBURSEMENT RATE				0.00

SC: 21-0013
EFFECTIVE DATE: 10/01/21
RO APPROVED: 11/08/2021
SUPERSEDES: SC 20-0010

PROVIDER NAME: 0
PROVIDER NUMBER: 0
REPORTING PERIOD: 10/01/19 through 09/30/20 DATE EFF. 10/01/21

MAXIMUM BED DAYS:(less Complex Care) 0
PATIENT DAYS USED: 0 PATIENT DAYS INCURRED: 0
TOTAL PROVIDER BEDS: 0 ACTUAL OCCUPANCY %: 0.00%
% Skilled 0.000% PATIENT DAYS @ 0.00% 0

COMPUTATION OF REIMBURSEMENT RATE - PERCENT SKILLED METHODOLOGY

	PROFIT INCENTIVE	TOTAL ALLOW COS	COST STANDARD	COMPUTED RATE
COSTS SUBJECT TO STANDARDS:				
GENERAL SERVICE		0.00	0.00	
DIETARY		0.00	0.00	
LAUNDRY/HOUSEKEEPING/MAINT.		0.00	0.00	
SUBTOTAL	0.00	0.00	0.00	0.00
ADMIN & MED REC	0.00	0.00	0.00	0.00
SUBTOTAL	0.00	0.00	0.00	0.00
COSTS NOT SUBJECT TO STANDARDS:				
UTILITIES		0.00		0.00
SPECIAL SERVICES		0.00		0.00
MEDICAL SUPPLIES AND OXYGEN		0.00		0.00
TAXES AND INSURANCE		0.00		0.00
LEGAL COST		0.00		0.00
SUBTOTAL		0.00		0.00
GRAND TOTAL		0.00		0.00
INFLATION FACTOR	3.50%			0.00
COST OF CAPITAL				0.00
PROFIT INCENTIVE (MAX 3.5% OF ALLOWABLE COST)			3.50%	0.00
COST INCENTIVE - FOR GENERAL SERVICE, DIETARY, LHM				0.00
EFFECT OF CAP ON COST/PROFIT INCENTIVES			\$1.75	0.00
SUBTOTAL				0.00
NON-EMERGENCY MEDICAL TRANSPORTATION (NEMT) ADD-ON				0.00
REIMBURSEMENT RATE				0.00
January 1, 2021 Medicaid Rate				0.00
Lower of Reimbursement Rate Above or January 1, 2021 Medicaid Rate due to Receipt and Forgiveness of PPP Loan Effective October 1, 2021				0.00

Effective October 1, 1995, for the purpose of establishing all cost center standards, the facilities are grouped according to bed size. The bed groupings are:

- 0 Through 60 Beds
- 61 Through 99 Beds
- 100 Plus Beds

- B. General Services cost center standards will be computed using private and non-state owned governmental free standing and hospital based nursing facilities. All other cost center standards will be computed using private for profit free standing nursing facilities.

A BRIEF DESCRIPTION ON THE CALCULATION OF ALL THE STANDARDS IS AS FOLLOWS:

1. General Services:

- a. Accumulate all allowable cost for the General Services cost center (Nursing & Restorative) for all facilities in each bed size.
- b. Determine total patient days by multiplying total beds for all facilities in each group by (366 x 90%).
- c. Calculate the mean cost per patient day by dividing total cost in (a) by total patient days in (b).
- d. Calculate the standard by multiplying the mean by 105%.
- e. The establishment of the General Services standard for all nursing facilities (excluding state owned facilities) will be based on the average of the percentage of Medicaid Level A patients/total Medicaid patients served. Rates effective on or after October 1, 2021 will be computed annually using nursing facility utilization (including nursing facility days paid under the Hospice Benefit) by patient acuity based upon the preceding July 1 through June 30 data period. Effective October 1, 2003, co-insurance days for dual eligibles are excluded from the computation. Effective December 31, 2011, nursing facility providers will no longer be allowed to appeal its acuity level (i.e. percent skilled) payment adjustment determination for any current or future year payment rates. The General Services standard for each separate facility will be determined in relation to the percent of Level A Medicaid patients served, i.e., the base standard determination in (d.) above will be decreased as the percent of Level A Medicaid patients is decreased and increased as the percent of Level A Medicaid patients is increased.

2. Dietary; Laundry, Maintenance and Housekeeping; Administration and Medical Records & Services: The standard for each of these three cost categories is calculated as follows:
 - a. Accumulate all allowable cost for each cost center for all facilities in each bed size.
 - b. Total patient days are determined by taking maximum bed days available from each bed group, subtracting complex care days associated with each bed group, and multiplying the net amount by 90%.
 - c. Calculate the mean cost per patient day by dividing total cost in (a) by total patient days in (b).
 - d. Calculate the standard by multiplying the mean by 105%.

C. Rate Computation

Rates will be computed using the attached rate computation sheet (see page 12) as follows:

1. For each facility, determine allowable cost for the following categories:

COST SUBJECT TO STANDARDS:

General Services
Dietary
Laundry, Maintenance and Housekeeping
Administration and Medical Records & Services

COST NOT SUBJECT TO STANDARDS:

Utilities
Special Services
Medical Supplies
Property Taxes and Insurance Coverage - Building and Equipment
Legal Fees

2. Calculate actual allowable cost per day based on the cost reports for each category by dividing allowable cost by total patient days as determined under section III A of Attachment 4.19-D.
3. For cost subject to standards, the lower of cost determined in step 2 or the cost standard will be allowed in determining the facility's rates. Effective October 1, 1997, the General Services, Dietary, and Laundry, Housekeeping, and Maintenance cost centers are combined. Therefore, compare the sum of the allowable cost of these three cost centers to the sum of these three cost standards.

4. For costs not subject to standards, the cost determined in step 2 will be allowed in determining the facility's rate.
5. Accumulate per diem costs determined in steps 3 and 4.
6. Inflate the cost in step 5 by multiplying the cost in step 5, by the inflation factor. The maximum inflation factor that can be used will be that provided by the State of South Carolina Revenue and Fiscal Affairs Office and is determined as follows:
 - a. Proxy indices for each of the eleven major expenditure components of nursing homes, (salaries, food, medical supplies, etc.) during the third quarter of 2021 were weighted by the expenditure weights of the long term care facilities. These eleven weighted indices are summed to one total proxy index for the third quarter of 2021.
 - b. Proxy indices are estimated for each of the eleven major expenditure components of nursing homes, (salaries, food, medical supplies, etc.), during the third quarter of 2022 and then weighted by the same expenditure weights as in step a. These weighted proxy indices were summed to one total proxy index for the third quarter of 2022.
 - c. The percent change in the total proxy index during the third quarter of 2021 (as calculated in step a), to the total proxy index in the third quarter of 2022 (as calculated in step b), was 3.50%. Effective October 1, 2021 the inflation factor used was 3.50%.

10. Effective for services provided on or after October 1, 2019, the Medicaid Agency will determine the facility specific Non-Emergency Medical Transportation (NEMT) Add-On as follows:

- For nursing facilities that were not capped by the NEMT transport trip criteria developed by the agency to adjust for significant acuity and utilization shifts observed in the type of NEMT transports among some of the participants residing in the nursing facility and employed in the determination of the October 1, 2018 NEMT add-ons, each facility's October 1, 2021 NEMT add-on will be determined based upon twelve months of allowable Medicaid reimbursable NEMT costs incurred from October 1, 2019 through September 30, 2020 (FYE Sept. 30, 2020) divided by the number of incurred FYE Sept. 30, 2020 Medicaid days as reported on provider cost reports.

For nursing facilities that were capped by the NEMT transport trip criteria developed by the agency to adjust for significant acuity and utilization shifts observed in the type of NEMT transports among some of the participants residing in the nursing facility and employed in the determination of the October 1, 2018 NEMT add-ons, each facility's October 1, 2021 NEMT add-on will be determined based upon the lower of the NEMT add-on determined October 1, 2018 or twelve months of allowable Medicaid reimbursable NEMT costs incurred from October 1, 2019 through September 30, 2020 (FYE Sept. 30, 2020) divided by the number of incurred FYE Sept. 30, 2020 Medicaid days as reported on provider cost reports.

11. For rates effective October 1, 2021, the Medicaid reimbursement rate will be the total of costs accumulated in step 5, inflation, cost of capital, cost incentive/profit, and NEMT add-on per diem.

This report will be due within ninety (90) days after the end of the period of operation. Once new ownership or the prior owner begins operation of the facility, reimbursement will be determined as previously described for a new owner under paragraph E (2).

F. Payment for State Government Nursing Facilities and Institutions for Mental Diseases

Effective October 1, 2021, each state owned nursing facility owned and/or operated by the SC Department of Mental Health will receive a prospective payment rate based upon each facility's fiscal year 2020 cost report. Allowable cost will be defined in accordance with the Provider Reimbursement Manual HIM-15. Allowable costs will include all physician costs except for those physician costs that relate to the provision of professional services. The total allowable Medicaid reimbursable costs of each nursing facility will be divided by the total number of actual patient days served during the cost reporting period to determine the base year Medicaid per diem cost. In order to trend the base Medicaid per diem cost to the payment period, the agency will employ the use of a midpoint to midpoint trend factor of 5.092% based upon the Third quarter 2020 Global Insight Indexes 2014 used for the CMS Skilled Nursing Facility Market Basket Updates.

The Medicaid Agency will not pay more than the provider's customary charge except governmental facilities that provide services free or at a nominal charge. Reimbursement to governmental facilities will be limited in accordance with 42 CFR §447.271 (b).

G. Payment Determination for ICF/IID's

1. All ICF/IID's shall apply the cost finding methods specified under 42 CFR 413.24(d) to its allowable costs for the cost reporting year under the South Carolina State Plan. ICF/IID facilities will not be subject to the allowable cost definitions R (A) through R (K) as defined in the plan.
2. All State owned/operated ICF/IID's are required to report costs on the Medicare Cost Reporting Form 2552. For cost reporting periods beginning on or after July 1, 1986, all other ICF/IID's which are not operated by the State (S.C. Department of Disabilities and Special Needs) will file annual financial and statistical report forms supplied by the Medicaid Agency. All cost reports must be filed with the Medicaid Agency within one hundred twenty (120) days from close of each fiscal year.

Effective April 1, 2019, all ICF/IID facilities will receive a statewide prospective payment rate (institutional rate or community rate) based upon the methodology described below using each facility's fiscal year 2016 cost report. Items of expense incurred by the ICF/IID facility in providing care are allowable costs for inclusion in the facility's cost report. These allowable costs are defined as items of expense which the provider may incur in meeting the definition of intermediate care or any expenses incurred in complying with state licensing or federal certification requirements. Allowable cost will be defined in accordance with the Provider Reimbursement Manual HIM-15.

To determine the April 1, 2019 baseline ICF/IID per diem rate, the total allowable Medicaid reimbursable costs of each ICF/IID will be divided by the total number of actual patient days served during the cost reporting period to determine the base year Medicaid per diem cost. In order to trend the base year Medicaid per diem cost to the midpoint of the FFY 2018 payment period, the agency will employ the use of the midpoint to midpoint methodology and the use of the first quarter 2018 Global Insight Indexes - 2014 Based CMS Skilled Nursing Home Market Basket Index.

Ventilator Unit Reimbursement Program

Effective for services provided on or after October 1, 2017, the South Carolina Department of Health and Human Services will update its per diem payment for services provided to ventilator dependent Medicaid beneficiaries residing in a ventilator dependent wing of a contracting South Carolina Medicaid nursing facility. To qualify for this reimbursement, the wing must consist of a minimum of 20 nursing facility beds that are dedicated solely to the provision of ventilator dependent services. Effective for services provided on and after October 1, 2021, the vent rate will equal \$560.00 per Medicaid patient day. This rate was determined based upon the Medicaid Agency's review of Medicare RUG rates associated with the provision of ventilator dependent services that are used to determine annual Essential Public Safety Net payments.

The ventilator unit rate will be used to reimburse nursing facilities for their base operational costs as well as the individual costs incurred in providing services to these individuals such as:

1. Staff time (both by skilled professional and nurse aides) to perform actual procedures or provide additional care;
2. Necessary supplies, specialized equipment such as lifts, special beds ventilators, etc. needed to provide the care, and/or nutritional supplements; and
3. Staff education required to be able to provide for the beneficiary with vent needs.

Nursing facilities that provide services to Ventilator Unit individuals will be required to step down cost applicable to this service in accordance with Section I (C) of Attachment 4.19-D upon submission of their annual cost report.

J. Payment for Out-of-State Long Term Care Facilities

In order to provide services to the South Carolina Medicaid patients awaiting placement into a nursing facility, the agency will contract with out-of-state facilities at the other states' Medicaid reimbursement rate. The agency will use the out-of-state facility's survey conducted by their survey and certification agency for our survey and certification purposes. Placement of a South Carolina Medicaid recipient into an out-of-state facility will only occur if a bed is unavailable in South Carolina. No year end South Carolina Medicaid long term care cost report will be required from the participating out-of-state facilities.

K. Upper Payment Limit Calculation

I. Private Nursing Facility Services

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

The most recently filed FYE Medicare nursing facility cost report serves as the base year cost report to be used for Medicaid UPL demonstrations. In order to determine the Medicare allowable cost per patient day (i.e. upper payment limit), the SCDHHS will:

- (1) Access the most recent and available CMS cost based UPL template for SC Medicaid UPL demonstration purposes.
- (2) Gather each nursing facility's Medicare Routine Cost Per Diem from worksheet D-1, Part I, Column 1, Line 16.
- (3) Determine and calculate the adjustments that would impact the Medicare Routine Cost Per Diem. This adjustment reflects the per diem costs of the ancillary services which are covered by the SC Medicaid nursing facility per diem rate which includes, but is not limited to, PT, OT, ST, Medical Supplies, Specialty Beds, and etc. The covered ancillary service costs are accumulated by each nursing facility and divided by total incurred patient days as reported on worksheet S-3, Part I, Column 7, Line 1 to arrive at the covered SC Medicaid ancillary per diem adjustment.
- (4) To determine the Total Medicare Cost Per Diem, add the Medicare Routine Cost Per Diem in step (2) above to the covered SC Medicaid ancillary per diem adjustment as reflected in step (3) above to arrive at the Total Medicare Cost Per Diem.
- (5) To trend the Total Medicare Cost Per Diem to the UPL demonstration period, the Medicaid Agency will employ the midpoint to midpoint trending methodology using the Global Insight CMS Nursing Home without Capital Market Basket Index in order to trend the base year cost to the Medicaid rate period.
- (6) Gather each nursing facility's Medicaid rate that is in effect during the Medicaid UPL demonstration period.
- (7) In order to adjust for items which are paid outside of the Medicaid per diem rates but have been included as an allowable cost in the determination of the Medicare Routine Cost Per Diems as described in step (2) above, a Medicaid rate per diem adjustment will be determined. Costs relating to CNA training and testing and professional liability claims will be accumulated for each individual nursing facility and then be divided by the number of total patient days used to determine the Medicaid per diem rate as described in (6) above.

- (8) To determine the Total Adjusted Medicaid per diem rate, add the Medicaid Per Diem in step (6) above to the SC Medicaid rate per diem adjustment as reflected in step (7) above.
- (9) Medicaid paid days (excluding NF days paid for recipients while under the Hospice Benefit) based upon the most recently completed state fiscal year are applied to the Total Adjusted Medicaid per diem rate as defined in (8) above and the Total Adjusted Medicare Cost Per Diem as described in step (4) above to arrive at the annual Medicaid payments for each provider as well as the annual Total Adjusted Medicare Cost expenditures for each provider.
- (10) The annual Total Adjusted Medicare Cost expenditures and the annual Medicaid rate expenditures for all providers within the class are summed to determine the aggregate payments for each class.
- (11) The Medicaid UPL compliance check is determined by comparing the aggregate amounts as determined in (9) above to ensure that Total Adjusted Medicare Cost expenditures are equal to or greater than Medicaid rate expenditures. In the event that aggregate Medicaid rate expenditures exceed aggregate Total Adjusted Medicare Cost expenditures, the Medicaid rate for each facility will be limited to the Total Medicare Cost Per Diem as determined in (4) above.

The sum of the private UPL payments will not exceed the upper payment limit calculated under the FFY 2022 private nursing facility UPL demonstration.

II. Non-State Owned Governmental Nursing Facility

The following methodology is used to estimate the annual upper payment limit applicable to non-state owned governmental nursing facilities:

The two most recent quarterly nursing facility UPL payments paid during the preceding federal fiscal year serves as the base data used for the annual Medicaid UPL demonstration for this ownership class and is described below:

- (1) Calculated Medicare upper payment limits for the December and March quarters of the preceding federal fiscal year are determined in accordance with the Essential Public Safety Net Nursing Facility Payment Program as described in Section III(K) of Attachment 4.19-D. Additionally, the Medicaid paid days associated with each quarter are identified via MMIS and exclude hospice days.
- (2) To estimate the calculated Medicare upper payment limit for the June and September quarters, the payments for the two preceding quarters are summed and divided by two for each nursing facility. The estimated Medicaid paid days for the June and September quarters are also determined using the same methodology.
- (3) The calculated quarterly Medicare upper payment limits identified in (1) above are added to the estimated June and September quarters' Medicare upper payment limit as identified in step (2) to determine the annual estimated Medicare upper payment limit for the preceding federal fiscal year for each nursing facility. Annual estimated Medicaid paid days for the preceding federal fiscal year are also determined using the same methodology.

(1) Qualifications

In order to qualify for a supplemental payment as an Essential Public Safety Net nursing facility, a nursing facility must meet all of the following criteria:

- a) The nursing facility is a non-state owned governmental nursing facility in which the operator of the nursing facility is also the owner of the nursing facility assets;
- b) The nursing facility is located in the State of South Carolina;
- c) The nursing facility is licensed as a nursing facility by the State of South Carolina and is a current Medicaid provider;

(2) Upper Payment Limit Calculation

The upper payment limit effective for services beginning on and after October 1, 2011 for Essential Public Safety Net nursing facilities will be calculated using the Medicaid frequency distribution of all licensed South Carolina non-state owned governmental nursing facilities which contract with the South Carolina Medicaid Program. This frequency distribution will be determined using the Medicaid MDS assessments completed during the period which corresponds with the quarterly upper payment limit payment period (e.g. October 1 through December 31 and January 1 through March 31, etc.). The results of each nursing facility's Medicaid frequency distribution will then be applied to the total Medicaid patient days (excludes hospice room and board Medicaid patient days and coinsurance days) paid to the nursing facility during each federal fiscal year beginning October 1, 2011 in order to allocate the Medicaid days across the Medicare RUG IV categories. The applicable Medicare rates for the payment year for each RUG category will be applied against the Medicaid days for each RUG category, and then summed, to determine the maximum upper payment limit to be used in the determination of the Essential Public Safety Net nursing facility payments.

Due to Medicare's conversion from the RUGS-IV payment methodology to the Patient Driven Payment Model for Medicare Part A skilled nursing facility services effective October 1, 2019, the Medicaid Agency will increase the October 1, 2018 Medicare RUGS-IV payment rates by the average annual increase in Medicare rates per the FY 2020, 2021, and 2022 Final Rule. The adjusted Medicare rates will then be used in the calculation of the quarterly Essential Public Safety Net Nursing Facility payments effective for services provided on and after October 1, 2021.

In order to adjust for program differences between the Medicare and Medicaid payment programs, the SCDHHS will calculate Medicaid payments in accordance with Section K(3)(b) of the plan.

(3) Payment Methodology

The South Carolina Department of Health and Human Services will make a supplemental Medicaid payment in addition to the standard nursing facility reimbursement to qualifying Essential Public Safety Net nursing facilities. Such payments will be made quarterly based on Medicaid patient days paid during the payment period. The payment methodology is as follows:

- a. The upper payment limit for all licensed South Carolina non-state owned governmental nursing facilities which contract with the South Carolina Medicaid Program will be computed as described under section K(II)(2) above.

JOB TITLE	0-60 BEDS MAX ALLOWED ANNUAL SALARY	61-99 BEDS MAX ALLOWED ANNUAL SALARY	100+ BEDS MAX ALLOWED ANNUAL SALARY
DIRECTOR OF NURSING (DON)	\$79,326	\$83,994	\$104,532
RN	\$59,998	\$60,784	\$64,072
LPN	\$48,966	\$48,966	\$51,152
CNA	\$24,823	\$24,823	\$26,520
SOCIAL SERVICES DIRECTOR	\$40,671	\$42,263	\$52,552
SOCIAL SERVICES ASSISTANT	\$34,731	\$34,731	\$40,586
ACTIVITY DIRECTOR	\$33,691	\$34,561	\$37,531
ACTIVITY ASSISTANT	\$22,468	\$22,913	\$25,078
DIETARY SUPERVISOR	\$41,265	\$45,657	\$56,350
DIETARY WORKER	\$20,177	\$21,385	\$24,229
LAUNDRY SUPERVISOR	\$29,681	\$29,681	\$29,681
LAUNDRY WORKER	\$17,949	\$19,731	\$22,022
HOUSEKEEPING SUPERVISOR	\$29,321	\$35,367	\$39,207
HOUSEKEEPING WORKER	\$18,733	\$19,668	\$21,407
MAINTENANCE SUPERVISOR	\$39,122	\$43,705	\$51,788
MAINTENANCE WORKER	\$28,578	\$28,684	\$32,058
ADMINISTRATOR	\$91,547	\$103,237	\$134,213
ASSISTANT ADMINISTRATOR	\$66,957	\$79,517	\$79,517
BOOKKEEPER / BUSINESS MGR	\$46,208	\$46,208	\$48,669
SECRETARY / RECEPTIONIST	\$28,981	\$29,278	\$30,636
MEDICAL RECORDS SECRETARY	\$36,916	\$36,916	\$36,916

Note: No change to prior year guidelines-no state employee pay increase effective 7/1/20.

G) ALLOWABLE COMPENSATION RANGES FOR OWNERS AND/OR THEIR RELATIVES
EMPLOYED BY PARENT COMPANIES:

JOB TITLE	% - CEO Compensation	0-60 BEDS	61-99 BEDS	100-257 BEDS	258 + BEDS
CEO	see nh admin. Guidelines	\$91,547	\$103,237	\$134,213	130%* 100+ admin. Guidelines \$174,476
ASST CEO					
CONTROLLER					
CORPORATE SECRETARY					
CORPORATE TREASURER					
ATTORNEY	75%	\$68,660	\$77,428	\$100,659	\$130,857
ACCOUNTANT					
BUSINESS MGR					
PURCHASING AGENT					
REGIONAL ADMINISTRATOR					
REGIONAL V-P					
REGIONAL EXECUTIVE	70%	\$64,083	\$72,266	\$93,949	\$122,133
CONSULTANTS:					
SOCIAL					
ACTIVITY					
DIETARY (RD)					
PHYSICAL THER (RPT)					
MEDICAL RECORDS (RRA)					
NURSING (BSRN)	65%	\$59,506	\$67,104	\$87,238	\$113,409
SECRETARIES	see nh	\$28,981	\$29,278	\$30,636	\$30,636
BOOKKEEPERS	see nh	\$46,208	\$46,208	\$48,669	\$48,669
MEDICAL DIRECTOR	90%	\$82,392	\$92,914	\$120,791	157,028
**NOTE: there are no home offices in the 0-60 bed group					

Note: No change to prior year guidelines-no state employee pay increase effective 7/1/20.

1. The above are maximum limits of allowable cost for owners and/or relatives who are actually performing these duties 100% of a normal work week. Part-time performance will be computed according to time spent. No individual will have more than one full time equivalent (40 hour per week) job recognized in the Medicaid program.
2. No assistant operating executive will be authorized for a chain with 257 beds or less.

P) COVID-19 Related Costs and Federal Paycheck Protection Program Revenue CARES ACT

All COVID-19 related expenses have been removed from the fiscal year ending September 30, 2020 and June 30, 2020 SC Medicaid cost reports for the determination of the October 1, 2021 payment rates. Therefore, the list of the following costs associated with COVID-19, while not all-inclusive, have been removed: COVID-19 nursing salaries, nursing hero bonuses, nursing isolating pay, other salaries, other hero bonuses, other isolating pay, fringe benefits related nursing and other areas' salaries, nursing consultant, nursing contract labor, minor equipment maintenance, telehealth equipment, electronic devices, nursing supplies, housekeeping supplies, non-capital facility modifications, paper and plastic supplies, billable COVID-19 testing costs, other costs, and non-billable COVID-19 testing costs.

The COVID-19 related costs identified above will be used to justify the four percent (4%) COVID-19 add-on Medicaid reimbursement provided during the March 1, 2020 through September 30, 2020 payment period. The Medicaid Agency will ensure compliance with the guidelines/instructions relating to the reporting requirements of the CARES ACT. The Medicaid Agency will remain flexible in its approach during its 4% COVID-19 add-on reconciliation process to account for any unknown changes that may be made to the CARES ACT reporting requirements that may occur after the time of this state plan submission.

Paycheck Protection Program (PPP) Revenue

For any nursing facility seeking/receiving forgiveness of funds provided via the Federal Paycheck Protection Program (PPP) that were received during its fiscal year ending 2020 cost reporting period, their October 1, 2021 Medicaid reimbursement rate will be limited to the lower of its October 1, 2021 rate computed using the FYE September 30, 2020 SC Medicaid cost report or its January 1, 2021 Medicaid reimbursement rate.

Any nursing facility that received PPP revenue subject to the provisions reflected above and undergoes a change in ownership will be subject to the rate setting provisions as outlined in Section III.E.3 of Attachment 4.19-D.