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State/Territory Name: South Carolina

State Plan Amendment (SPA) #: 09-007

This file contains the following documents in the order listed:

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

Center for Medicaid and State Operations (CMSO)

OCT - 6 2009

Ms. Emma Forkner
Director
Department of Health and Human Services
P.O. Box 8206
Columbia, South Carolina 29202-8206

RE: SPA SC 09-007

Dear Ms. Forkner:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number 09-007. Effective October 1, 2009 this amendment modifies the State's reimbursement methodology for setting payment rates for nursing facility services. Specifically, this amendment updates nursing facility rates based on cost reports from fiscal year 2008 indexed for inflation to the rate year 2010 and includes language that requires the offset of any funds received by a nursing facility from the quality initiative grant awards program.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(13), 1902(a)(30) and 1903(a) of the Social Security Act and the implementing Federal regulations at 42 CFR Part 447. 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, 2009. 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 or Venesa Day at 410-786-8281.

Sincerely,

//s//

Cindy Mann
Director, CMSO

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	1. TRANSMITTAL NUMBER: SC 09-007	2. STATE South Carolina
FOR: HEALTH CARE FINANCING ADMINISTRATION	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE October 1, 2009	

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:	7. FEDERAL BUDGET IMPACT:
42 CFR, Subpart C	($22,500,000 - 5,000,000) X 79.36% a. FFY 2010 $13,888,000 b. FFY 2011 $Rates will be rebased
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-D, Pages 6, 8, 19 through 23, 32, 37, 39 and 42 through 45	Attachment 4.19-D, Pages 6, 8, 19 through 23, 32, 37, 39 and 42 through 45

10. SUBJECT OF AMENDMENT:
Nursing Facility rate update effective October 1, 2009 based upon annual rebasing and update to the Upper Payment Limit Reimbursement Program for Essential Public Safety Net Nursing Facilities.

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

12. SIGNATURE OF STATE AGENCY OFFICIAL: //s//	16. RETURN TO: South Carolina Department of Health and Human Services Post Office Box 8206 Columbia, SC 29202-8206
13. TYPED NAME: Emma Forkner	
14. TITLE: Director	
15. DATE SUBMITTED: 07-30-09	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 07-30-09	18. DATE APPROVED: 10-06-09
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: 09-01-09	20. SIGNATURE OF REGIONAL OFFICIAL: //s//
21. TYPED NAME: Cindy Mann	22. TITLE: Director, CMSO
23. REMARKS:	

Since the return on capital payment is provided as an incentive for the expansion of Medicaid services by the private sector, only those facilities that were established as profit earning centers were selected for the calculation of the base period costs. Non-profit facilities were excluded from the base period calculation.

2) Inflation Adjustment To Current Period "Deemed Asset Value"

The plan uses the index for the rental value of a home computed as part of the CPI as the appropriate measure for approximating the increase in the value of nursing home assets in South Carolina since 1980-1981. This index measures the increase in the amount that homeowners on average could get for renting their homes. For the period from 1980-1981 through the federal cost year 2007-2008, this index rose 203.131 percent.

Inflating the base period market value of $15,618 by the index for homeowner's rent, the "Deemed Asset Value" for cost year 2007-2008 is $47,343 per bed and will be used in the determination of nursing facility rates beginning October 1, 2009.

3) Calculation of "Deemed Depreciated Value"

The plan will exclude depreciation payments already received by operators from the Deemed Asset Value on the theory that the depreciation charges represent a reasonable valuation of the decline in the worth of the assets from old age. The result is the "Deemed Depreciated Value."

For a facility existing prior to July 1, 1989, the plan will continue to reimburse for actual depreciation costs based on a straight line apportionment of the original cost of the facility and the actual value of any additions. Effective October 1, 1990, for new facilities established or new beds entering the Medicaid Program on and after July 1, 1989, depreciation payments will be set based on actual construction costs, or the Deemed Asset Value when the facility begins operations, whichever is lower, and on applicable Medicare guidelines for depreciation. However, building depreciation for all new facilities/new beds on line on or after July 1, 1991 will be assigned a useful life of 40 years. Accumulated depreciation to be used to offset the deemed asset value for new facilities will be based on accumulated allowed depreciation (i.e. the lesser of actual depreciation or that determined by the Deemed Asset Value).

For bed increases of less than 50% (i.e. no six months cost report is filed), recognition of capital costs will be made at the point in time these beds are certified for Medicaid participation. For clarification, the Deemed Asset Value in effect at the time the beds are certified for Medicaid

could be raised by borrowing from the banks. But this would be rather costly for the small investor, who would probably have to pay a rate of interest in excess of the prime rate.

The plan sets the rate of return for a fiscal year at the average of rates for thirty year Treasury bonds (effective 2007) and twenty year Treasury bonds (through 2006) for the latest three completed calendar years prior to the fiscal year, as determined by the Division of Research and Statistics of the Budget and Control Board, based on latest data published by the Federal Reserve. Effective October 1, 2009, this rate is 4.71%.

Acknowledging a newly constructed facility's plight of high per bed construction costs and interest rates as great and greater than the market rate of return, the rate of return for these facilities will be the greater of the interest rate incurred by the facility or the industry market rate of return as determined by the Budget and Control Board. These facilities will only be allowed their interest rate (if greater) during a transition period which is defined as the rate period beginning with the facility's entrance into the Medicaid program and ending at that point in time in which the facility files its first annual FYE September 30 cost report that will be used to establish the October 1 rate (i.e. period ends September 30). In no circumstances will the allowed interest rate exceed 3% above the industry market rate of return.

5) Additions To Facilities After 1981

The plan intends to provide adequate incentives for the expansion of nursing home services by the private sector of the state. The Deemed Depreciated Value takes into account the wearing out of facilities, but does not include any factor for additions or upgradings to the facilities. Operators who have made capital improvements to their facilities since 1981 are permitted to add the amount of the investment to their Deemed Asset Value. Operators are also permitted to add the cost of future additions and upgradings of facilities to their Deemed Asset Value. This provision will provide an incentive to operators to reinvest part of their cash flow back into the facility to maintain and improve the level of service provided by the operator. For clarification purposes, capital expenditures incurred by new beds on line on or after July 1, 1989 during the initial cost reporting period will not be considered as improvements, but as part of actual construction costs.

6) Computation of Cost of Capital

The cost of capital for each patient day served would be calculated for each nursing home based on the Deemed Asset Value. The computation of the rate of reimbursement for the cost of capital is illustrated below in Table 1 for the

PROVIDER NAME:	0			
PROVIDER NUMBER:	0			
REPORTING PERIOD:	10/01/07	through	09/30/08	DATE EFF. 10/1/2009

		MAXIMUM BED DAYS:	0
PATIENT DAYS USED:	0	PATIENT DAYS INCURRED:	0
TOTAL PROVIDER BEDS:	0	ACTUAL OCCUPANCY %:	0.00
% LEVEL A	0.000	PATIENT DAYS @ 0.96	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 4.70%				0.00
COST OF CAPITAL				0.00
PROFIT INCENTIVE (MAX 3.5% OF ALLOWABLE COST)				0.00
COST INCENTIVE - FOR GENERAL SERVICE, DIETARY, LHM				0.00
EFFECT OF $1.75 CAP ON COST/PROFIT INCENTIVES			$0.00	0.00
REIMBURSEMENT RATE				0.00

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SUPERSEDES: SC 08-017

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. ALL STANDARDS, EXCEPT FOR GENERAL SERVICES, FOR PROPRIETARY AND NONPROFIT FACILITIES (EXCLUDING STATE OWNED) WILL BE COMPUTED USING PROPRIETARY FACILITIES ONLY. EFFECTIVE OCTOBER 1, 1997, HOSPITAL BASED PROPRIETARY NURSING FACILITIES WILL BE EXCLUDED FROM THE COMPUTATION OF ALL STANDARDS, EXCEPT FOR GENERAL SERVICES. THE GENERAL SERVICE STANDARD WILL BE COMPUTED USING PROPRIETARY AND NONPROFIT FACILITIES (EXCLUDING STATE OWNED). 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 96%).]

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, 2000 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. 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. Determine total patient days by multiplying total beds for all facilities in each group by (366 x 96%).

   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 19) 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 actual days. If the facility has less than 96% occupancy, actual days will be adjusted to reflect 96% occupancy.

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 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 Division of Research and Statistical Services 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 2009 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 2009.

   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 2010 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 2010.

   c. The percent change in the total proxy index during the third quarter of 2009 (as calculated in step a), to the total proxy index in the third quarter of 2010 (as calculated in step b), was 4.7%. Effective October 1, 2009 the inflation factor used was 4.7%.

7. The per patient day cost of capital will be calculated by dividing capital cost as determined under I.(F)(c) of this plan by actual patient days. However, if the facility has less than 96% occupancy, actual days will be adjusted to reflect 96% occupancy.

8. Cost Incentive - General Services, Dietary, and Laundry, Housekeeping, and Maintenance

   If the facility's actual allowable costs for these three cost centers are below the sum of these three allowable cost standards, the facility will be eligible for a cost incentive of an amount equal to the difference between the sum of the standards and the sum of the facility's actual costs, up to 7% of the sum of the standards.

9. Profit will be allowed if the provider's allowable cost is lower than the standard as follows:

a. Administration and Medical Records & Services - 100% of difference with no limitation.

Ceiling on profit will be limited to 3 1/2% of the sum of the provider's allowable cost determined in step 2. The sum of the cost incentive and the profit cannot exceed $1.75 per patient day.

10. For rates effective October 1, 2009, the provider's reimbursement rate under this concept will be the total of costs accumulated in step 6, cost of capital, cost incentive and profit.

D. Payment for Hospital-based and Non-profit Facilities

Hospital-based and non-profit facilities will be paid in accordance with Sections III A, B, and C.

E. Payment determination for a new facility, replacement facility, change of ownership through a purchase of fixed assets, change of ownership through a lease of fixed assets, when a facility changes its bed capacity by more than fifty percent (50%), or when temporary management is assigned by the state agency to run a facility.

1. Payment determination for a new facility or a facility that changes its bed capacity by more than fifty percent (50%):

The following methodology shall be utilized to determine the rate to be paid to a new facility or a facility that changes its bed capacity by more than fifty percent (50%):

Based on a six (6) month's projected budget of allowable costs covering the first six months of the Provider's operation under the Medicaid program, the Medicaid agency will set an interim rate to cover the first six (6) months of operation or through the last day of the sixth (6^{th}) full calendar month of operation. The same rate setting methodology previously described will be applied to the provider's allowable costs in determining the rate except that all standards to be used will be one hundred twenty percent (120%) of the standards for the size of facility to adjust for lower initial occupancy. The one hundred twenty percent (120%) adjustment is determined by considering the average eighty percent (80%) occupancy for the first six (6) months of operation of a new facility versus the minimum of ninety-six percent (96%) occupancy required for all facilities that have been in operation for more than six (6) months.

(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;
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;

and one of the following criteria:

(i) The nursing facility is hospital based; or
(ii) The nursing facility is owned by a rural non-state owned governmental hospital and the total licensed beds owned by the hospital at all of its nursing facilities exceeds 200 beds; or
(iii) The nursing facility's total licensed beds is in excess of 300 beds.

(2) Upper Payment Limit Calculation

[The upper payment limit effective for services beginning on and after October 1, 2008 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 most recently completed calendar year (i.e. January 1 through December 31) prior to the effective date of the plan amendment. The results of each nursing facility's Medicaid frequency distribution will then be applied to the total Medicaid patient days (less coinsurance days) paid to the nursing facility during each federal fiscal year beginning October 1, 2008 in order to allocate the Medicaid days across the 53 Medicare RUG 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.]

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 on an annual basis after services have been furnished. 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(2) above.

F) Compensation: (Direct and Indirect) (These limits below do not include fringe benefits provided on a non-discriminatory basis.) ALLOWABLE COMPENSATION RANGES FOR OWNERS (LESSORS) AND/OR THEIR RELATIVES AND LESSEES AND/OR THEIR RELATIVES:

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)	$60,062	$65,419	$79,704
RN	$51,785	$51,785	$53,193
LPN	$40,063	$40,650	$42,520
CAN	$20,399	$20,650	$21,428
SOCIAL SERVICES DIRECTOR	$28,928	$33,718	$41,491
SOCIAL SERVICES ASSISTANT	$21,512	$23,487	$32,100
ACTIVITY DIRECTOR	$23,887	$26,743	$30,335
ACTIVITY ASSISTANT	$17,647	$21,155	$21,155
DIETARY SUPERVISOR	$31,239	$34,642	$44,201
DIETARY WORKER	$16,995	$17,941	$19,033
LAUNDRY SUPERVISOR	$18,676	$21,134	$28,886
LAUNDRY WORKER	$16,009	$17,038	$17,038
HOUSEKEEPING SUPERVISOR	$20,819	$23,382	$30,966
HOUSEKEEPING WORKER	$15,168	$16,429	$17,773
MAINTENANCE SUPERVISOR	$29,8 31	$33,928	$41,995
MAINTENANCE WORKER	$28,046	$28,046	$28,046
ADMINISTRATOR	$66,700	$81,112	$101,237
ASSISTANT ADMINISTRATOR	$30,252	$48,696	$60,671
BOOKKEEPER / BUSINESS MGR	$32,352	$32,751	$39,768
SECRETARY / RECEPTIONIST	$20,650	$21,806	$25,398
MEDICAL RECORDS SECRETARY	$23,802	$24,832	$25,357

Note: Last year guidelines were increased by 1.0%--the state employee pay increase effective 07/01/08

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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	$66,700	$81,112	$101,237	130%* 100+ admin. Guidelines	$131,608
ASST CEO CONTROLLER CORPORATE SECRETARY CORPORATE TREASURER ATTORNEY	75%	$50,025	$60,834	$75,928		$98,706
ACCOUNTANT BUSINESS MGR PURCHASING AGENT REGIONAL ADMINISTRATOR REGIONAL V-P REGIONAL EXECUTIVE	70%	$46,690	$56,778	$70,866		$92,126
CONSULTANTS: SOCIAL ACTIVITY DIETARY (RD) PHYSICAL THER (RPT) MEDICAL RECORDS (RRA) NURSING (BSRN)	65%	$43,355	$52,723	$65,804		$85,545
SECRETARIES	see nh	$20,650	$21,806	$25,398		$25,398
BOOKKEEPERS	see nh	$32,352	$32,751	$39,768		$39,768
MEDICAL DIRECTOR	90%	$60,030	$73,001	$91,113		$118,447

****NOTE: there are no home offices in the 0-60 bed group**

Note: Last year guidelines were increased by 1.0%--the state employee pay increase effective 07/01/08

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.

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N) Eden Alternative Expenses

The costs incurred by nursing facilities which participate in adopting the Eden Alternative concept will be considered an allowable cost for Medicaid rate setting purposes. The goals of the Eden Alternative are to improve the quality of life in nursing facilities, and transform the conventional nursing facility into a vibrant human habitat for its residents. The incorporation of gardens, animals, birds, and children into the daily activities of the nursing facility residents assists in meeting these goals.

As with all other allowable Medicaid costs, these costs will be subject to reasonableness and must be related to patient care. Additionally, Eden Alternative expenses must be offset by grant income. Costs associated with fund raising activities applicable to the Eden Alternative concept or any other fund raising program will not be considered an allowable cost for Medicaid rate setting purposes.

O) Quality Initiatives Grant Awards

The goal of the Quality Initiatives Grant Award Program administered by the Medicaid Agency is to enhance the quality of care and quality of life for nursing facility residents and staff through initiatives that focus on education. Nursing facilities that participate in this Quality Initiative Program will receive grant funding that must be used to fund one of the approved quality enhancing initiative items: (1) subscription costs related to "My Inner View", an independent survey and benchmarking company measuring quality in long-term care and assisted living facilities; (2) Bladder Scanner, or (3) Electronic Medical Records System. While the costs of the items listed above will be included as an allowable cost for Medicaid rate setting, nursing facilities must offset the costs of these items by the amount of the grants award received from the Medicaid Agency.

P) Professional Liability, Workers' Compensation, and Health Insurance Costs

A provider participating in the South Carolina Medicaid Program is expected to follow sound and prudent management practices, including the maintenance of an adequate insurance program to protect itself against likely losses, particularly losses so great that the provider's financial stability would be threatened. There are various types of insurance coverage that are allowable costs for South Carolina Medicaid reimbursement purposes and they, as well as their allowable cost requirements, are defined in the Provider Reimbursement Manual HIM-15, sections 2161 through 2162.14. However, due to recent questions relating to providers' treatment of professional liability, workers' compensation, and health insurance costs, the South Carolina

Department of Health and Human Services (SCDHHS) is providing the following clarification/new policy to address the questions raised for the three insurance programs.

The provider may choose to protect itself against professional liability, workers' compensation, and health insurance costs through the use of one of the following methods:

1. Insurance purchased from a commercial insurance company which provides coverage after a deductible or coinsurance provision has been met;

2. Insurance purchased from a limited purpose insurance company (captive);

3. Total self insurance; or

4. A combination of purchased insurance and self-insurance.

In order for the losses and the costs associated with the purchase of insurance coverage to be considered as an allowable
cost for South Carolina Medicaid reimbursement purposes, all pertinent provisions of the Provider Reimbursement Manual HIM-15 must be met. This would include those sections of HIM-15 relating to losses arising from other than sale of assets (i.e. all sections of 2160 through 2160.5) and those sections of HIM-15 relating to insurance (i.e. all sections of 2161 through 2162.14). In addition, the state will clarify existing requirements and impose new requirements effective October 1, 2007:

- No more than twelve months of claims expense will be allowed during a full cost reporting period;

- Professional liability punitive damage awards are not considered an allowable cost for South Carolina Medicaid reimbursement purposes.

- Effective October 1, 2007, free standing nursing facilities as well as chain nursing facilities must ensure that South Carolina specific data is used in claiming allowable insurance costs for its South Carolina nursing facilities.

- For cost reporting periods beginning on or after October 1, 2007, when a change is made from commercial insurance to one of the alternatives listed above or from one alternative to another, the provider must document and submit to the SCDHHS a comparative analysis which shows that the provider's choice results in a reasonable cost for the coverage offered and that the extent of the coverage is consistent with sound management practices. The provider's comparative analysis must be performed every three (3) years to assure consistent

application of the prudent buyer principle and to properly monitor the cost effectiveness of the insuring method being applied. The provider must provide these analyses for review by the SCDHHS and/or the Office of the State Auditor (SAO). The analyses must include the information as reflected in HIM-15, section 2162.C.

- Providers that are currently operating under insurance coverage other than commercial insurance are required to perform a comparative analysis every three (3) years to assure consistent application of the prudent buyer principle and to properly monitor the cost effectiveness of the insuring method being applied. The provider must provide these analyses for review by the SCDHHS and/or the SAO. The analyses must include the information as reflected in HIM-15, section 2162.C. An insurance survey will be mailed to all contracting providers no later than March 31, 2008 to determine those providers that will be required to perform the comparative analysis and when it will be due.

- Effective October 1, 2007, providers cannot switch between claims paid and claims paid with incurred but not reported expenses (IBNR) factor without prior authorization from the SCDHHS.

Insurance Purchased from a Commercial Insurance Company

The reasonable costs of insurance purchased from a commercial carrier are allowable if the type, extent, and cost of coverage are consistent with sound management practice (HIM-15, sections 2161.A., 2162.1, 2160.B). The premiums paid under this coverage will be an allowable cost for South Carolina Medicaid reimbursement purposes using GAAP and HIM -15 reimbursement principles to allocate the expense between cost reporting periods.

Insurance Purchased from a Limited Purpose Insurance Company (Captive)

See HIM-15, section 2162.2 for South Carolina Medicaid allowable cost reimbursement requirements.

Total Self-Insurance

A provider must meet all of the conditions set forth in HIM-15, section 2162.7 to be designated as "self-insured" by the South Carolina Medicaid Program. Under this designation, providers will be required to claim as cost the actuarial determined amount to be paid into the fund in accordance with HIM-15. Expenses related to losses paid out of the self-insurance fund as described in HIM-15, section 2162.8 will be considered an allowable cost for South Carolina Medicaid reimbursement purposes. Those expenses specifically identified in section 2162.8 will become part of the cost of the particular insurance coverage that meets the self-

insurance test while those not specifically identified will be considered an administrative cost. In the event that the

provider does not meet all of the "self-insurance" criteria as established in HIM-15, section 2162.7, the provider's allowable Medicaid reimbursable costs associated with insurance coverage will be limited to one of the following options:

(a) - actual claims paid during the cost reporting period; or

(b) - actual claims paid with a year end accrual for incurred but not reported (IBNR) expenses applicable to the cost reporting period. The IBNR factor will be determined based upon experience occurring during the three month period immediately following the end of the cost reporting period.

Allowability of actual loses related to deductibles or co-insurance will be determined in accordance with HIM-15, Section 2162.5.

Professional Liability Expense Only - Pool Payments

Effective October 1, 2007, providers will be reimbursed outside of their Medicaid reimbursement rate for Professional Liability claims that exceed $50,000 on an individual claim-by-claim basis. When a claim for payment is made under this provision, the provider will be required to submit to the SCDHHS a copy of the final settlement agreement and/or court or jury decision. Any settlement negotiated by the provider or award resulting from a court or jury decision of damages paid by the provider in excess of the provider's policy, as well as the reasonable cost of any legal assistance connected with the settlement or award will be considered an allowable Medicaid reimbursable cost, provided the provider submits evidence to the satisfaction of the SCDHHS and/or the SAO that the insurance coverage carried by the provider at the time of the loss reflected the decision of prudent management (HIM-15, section 2160.2).The reasonable legal costs associated with this claim will be reimbursed via the nursing facility's Medicaid per diem rate.

This payment will be made via a gross adjustment and Medicaid's portion of this payment will be determined based upon the Medicaid occupancy of the nursing facility during the cost-reporting period in which the claim is paid. Payments made under this method will be for those claims that have a final settlement date within the corresponding cost reporting period. For example, claims with a final settlement date occurring between October 1, 2005 through September 30, 2006 will be eligible for payment on or after October 1, 2007. The final settlement between the plaintiff and the nursing facility should indicate the amount of the payment for compensatory or actual damages and the amount of the payment for punitive damages. Professional liability punitive damage awards are not considered an allowable cost for South Carolina Medicaid reimbursement purposes. This payment will not be subject to the lower of cost or charges compliance test.