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State/Territory Name: South Carolina

State Plan Amendment (SPA) #: 12-0027

This file contains the following documents in the order listed:

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

Financial Management Group

December 1, 2017

Mr. Joshua D. Baker
Acting Director
Department of Health and Human Services
P.O. Box 8206
Columbia, South Carolina 29202-8206

RE: State Plan Amendment SC 12-0027

Dear Mr. Baker:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid state plan submitted under transmittal number (TN) 12-027. Effective October 1, 2012 this amendment modifies the State's reimbursement methodology for setting payment rates for state operated nursing facilities (NFs) and Intermediate Care Facilities for the Individuals with Intellectual Disabilities (ICF/IIDs). Specifically, this amendment will eliminate retrospective cost settlements for state operated NFs and ICF/IIDs and establish a prospective payment method.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a), 1902(a)(13), 1902(a)(30), and 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, 2012. We are enclosing the CMS-179 and the amended approved plan pages.

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

Sincerely,

//s//

Kristin Fan
Director

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL **FOR: HEALTH CARE FINANCING ADMINISTRATION**	1. TRANSMITTAL NUMBER: SC-12-027	2. STATE South Carolina
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE October 1, 2012	

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

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

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

6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR, Part 447	7. FEDERAL BUDGET IMPACT: a. FFY 2013 $ b. FFY 2014 $
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-D, pages 23, 24, 25, 30, 30a, and 30b	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Attachment 4.19-D, pages 23, 24, 25, 30, 30a, and 30b

10. SUBJECT OF AMENDMENT:
Elimination of retrospective cost settlements for state owned nursing facilities and ICF/IIDs effective October 1, 2012

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
x ☐ OTHER, AS SPECIFIED:
Mr. Keck 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 Service Post Office Box 8206 Columbia, SC 29202-8206
13. TYPED NAME: Anthony E. Keck	
14. TITLE: Director	
15. DATE SUBMITTED: December 18, 2012	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 12-28-12	18. DATE APPROVED: 12/01/17
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: 10/01/12	20. SIGNATURE OF REGIONAL OFFICIAL: //s//
21. TYPED NAME: Kristin Fan	22. TITLE: Director, FMG

23. REMARKS: Approved with the following changes to block 8 and 9 as authorized by state agency.

Block # 8 change to read: Attachment 4.19-D pages 23, 24, 25, 28, 28a, 28b, 30, 30a and 30b.

Block # 9 change to read: Attachment 4.19-D pages 23, 24, 25, 28, 28a, 30, 30a and 30b.

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, 2012, 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 2010 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 year Medicaid per diem cost to the payment period (October 1, 2012 - September 30, 2013), the agency will employ the use of the midpoint to midpoint methodology and the use of the CMS Skilled Nursing Facility PPS Market Based rate for fiscal year 2010 (2.2%).

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 October 1, 2012, all ICF/IID facilities will receive a prospective payment rate based upon each facility's fiscal year 2010 cost report. Allowable cost will be defined in accordance with the Provider Reimbursement Manual HIM-15. 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 payment period (October 1, 2012 - September 30, 2013), the agency will employ the use of the midpoint to midpoint methodology and the use of the CMS Skilled Nursing Facility PPS Market Based rate for fiscal year 2010 (2.2%).

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.

Medicaid payment to the ICF/IID includes, but is not limited to, reimbursement for the following services:

a) Room and board including all of the items necessary to furnish the individual's room (luxury items/fixtures will not be recognized as an allowable cost). 42 CFR §483.470(b), (c), (d), (e), (f), and (g)(1).

b) Direct care and nursing services as defined for each living unit of the facility. 42 CFR §483.460(c).

c) Training and assistance as required for the activities of daily living, including, but not limited to, toileting, bathing, personal hygiene and eating as appropriate. 42 CFR §483.440(a).

d) Walkers, wheelchairs, dental services, eyeglasses, hearing aids and other prosthetic or adaptive equipment as needed. If any of these services are reimbursable under a separate Medicaid program, the cost will be disallowed in the cost report (effective for cost reporting periods beginning July 1, 1989).

e) Maintenance in good repair of dentures, eyeglasses, hearing aids, braces, and other aids prescribed for a resident by an appropriate specialist effective for cost reporting periods beginning July 1, 1989. 42 CFR §483.470(g)(2).

f) Therapy services including, but not limited to, speech, recreation, physical, and occupational, as prescribed by the resident's individual habilitation plan. 42 CFR §483.430(b).

g) Transportation services as required to provide other services including vehicles with lifts or adaptive equipment, as needed. The cost of ambulance services will not be included as part of allowable costs.

h) Psychological services as described in 42 CFR §483.430(b)(1) and (b)(5)(v).

i) Recreational services as described in 42 CFR §483.430(b)(1) and (b)(5)(viii).

j) Social services as described in 42 CFR §483.430(b)(1) and (b)(5)(vi).

k) Speech and hearing services as described in 42 CFR §483.430(b)(1) and (b)(5)(vii).

l) Food and nutritional services as described in 42 CFR §483.480.

m) Safety and sanitation services as described in 42 CFR §483.470(a), (g)(3), (h), (i), (j), (k), and (l).

n) Physician services as described in 42 CFR §483.460(a).

Any service (except for physician services) that is required of an ICF/IID facility that is reimbursable under a separate Medicaid program area must be billed to the respective program area. Any costs of this nature cannot be claimed in the Medicaid cost report.

4. See Section Q which describes the certified public expenditure review process and retrospective cost settlement process for state owned/operated ICF/IIDs. 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).

H. Payment for Swing-Bed Hospitals

Effective July 1, 1989, the South Carolina Medicaid Program will participate in the provision of nursing facility services in swing bed hospitals. A rate will be determined in accordance with the payment methodology as outlined in this state plan, adjusted for the following conditions:

A) Effective October 1, 1992, all nursing facilities in operation will be used in the calculation of the rate.

B) The rate excludes the cost associated with therapy services.

C) The rate reflects a weighted average rate using the state's prior FYE June 30 Medicaid permit days. Effective July 1, 1991, projected Medicaid days were used.

I. Complex Care Reimbursement Program

Effective for services provided on or after October 1, 2011, the South Carolina Department of Health and Human Services will implement its Complex Care Program. The Complex Care Program is a patient assessment driven system that will provide financial incentives to nursing facilities who admit Medicaid beneficiaries with complex care needs. Medicaid beneficiaries who qualify for the Complex Care Program must meet the South Carolina Level of Care Criteria (Skilled or Intermediate) for Long Term Care and have multiple

b) Medicaid reimbursement payments for all licensed South Carolina non-state owned governmental nursing facilities which contract with the South Carolina Medicaid Program will be computed using the corresponding federal fiscal year Medicaid days paid during the period beginning October 1, 2011. The Medicaid reimbursement payments will incorporate: (1) the gross per diem payments based upon the Medicaid rate(s) in effect during the payment period as computed in accordance with the state plan, and (2) ancillary service payments which are not reflected within the gross Medicaid rate. The ancillary services would include pharmacy, lab, x-ray and ambulance. In order to determine these costs, only Medicaid eligible recipients residing in nursing facilities will be used. Additionally, Publications 12 (The Skilled Nursing Facility Manual) and 100-04 (Medicare Claims Processing Manual) will provide the criteria to be used in determining the appropriate pharmacy, lab, x-ray and ambulance services to be pulled. Eligibility information from MEDS as well as paid claims data from MMIS and/or Medstat will be used in the analysis. In order to adjust the ancillary service costs to a per patient day basis, the number of nursing facility days paid on behalf of each individual will also be accumulated from MMIS and/or Medstat.

c) The sum of the upper payment limit as described in K(3)(a) will be reduced by the sum of the Medicaid reimbursement payments as described in K(3)(b) to determine the amount of the upper payment limit payments to be paid to each Essential Public Safety Net nursing facilities (as defined in section K(1)).

The total payments made to the licensed South Carolina non-state owned governmental nursing facilities that contract with the South Carolina Medicaid Program, including the Essential Public Safety Net nursing facility supplemental payments, will not exceed the aggregate Upper Payment Limit amount for the non-state owned governmental nursing facilities. Additionally, the Essential Public Safety Net nursing facility supplemental payments will not be subject to the lower of costs or charges limitation.

IV. State Owned Governmental ICF/IID Service Providers

The following methodology is used to estimate the upper payment limit applicable to state owned governmental Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) facilities:

The SFY 2010 2552 cost report serves as the base year cost report to be used for Medicaid rate setting and UPL calculations. In order to determine the Medicare allowable cost using Medicare allowable cost principles (i.e. upper payment limit), the SCDHHS employs the following process:

(1) First, allowable Medicaid reimbursable cost for each ICF/IID is obtained from worksheet B Part I, Column 21 of the Medicaid Regional ICF/IID cost report. The Medicaid allowable reimbursable cost of each ICF/IID is then divided by total patient days incurred by each ICF/IID to determine the base year per diem cost of each ICF/IID. Total patient days are derived from the individual worksheet summaries provided within each Medicaid Regional ICF/IID cost report.

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SUPERSEDES: SC 11-021

(2) The Medicaid ICF/IID per diem cost as determined in step (1) for each facility is then trended by the compounding of three years of the Skilled Nursing Facility Market Basket Index rates (prior to productivity adjustment) utilized by Medicare in order to trend the base year per diem cost to the Medicaid rate period. This would include the use of the FY 2011, 2012 and 2013 Market Basket rates. To determine trended Medicaid ICF/IID cost for each ICF/IID for the October 1, 2012 through September 30, 2013 demonstration period, their individual trended per diem cost rate is multiplied by the base year Medicaid incurred patient days which is obtained via MMIS.

(3) Total annual projected Medicaid ICF/IID revenue of each facility for the October 1, 2012 through September 30, 2013 payment period is derived by taking the October 1, 2012 Medicaid rates of each ICF/IID facility and multiplying this rate by the facility's SFY 2010 incurred Medicaid days.

(4) The Medicaid UPL compliance check is determined for this class by comparing the aggregate amounts as determined in step (2) above to ensure that projected Medicaid ICF/IID cost is equal to or greater than projected Medicaid ICF/IID rate expenditures in step (3). In the event that aggregate Medicaid ICF/IID rate expenditures exceed aggregate Medicaid ICF/IID cost, the Medicaid ICF/IID rate for each facility will be limited to the Medicaid cost based rate as determined in (2) above.

V. State Owned Governmental Nursing Facility Service Providers

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

The SFY 2010 Medicaid nursing facility cost report serves as the base year cost report to be used for Medicaid rate setting and UPL calculations. In order to determine the Medicare allowable cost using Medicare allowable cost principles (i.e. upper payment limit), the SCDHHS employs the following process:

(1) First, allowable Medicaid reimbursable cost for each nursing facility is obtained from the adjusted column of The Revenue and Expense Summary worksheet of the Medicaid nursing facility cost report, less any applicable desk audit adjustments. The Medicaid allowable reimbursable cost of each nursing facility is then divided by total patient days incurred by each nursing facility to determine the base year per diem cost. Total patient days are derived from the Census worksheet contained within the Medicaid nursing facility cost report.

(2) The Medicaid nursing facility per diem cost as determined in step (1) for each facility is then trended by the compounding of three years of the Skilled Nursing Facility Market Basket Index rates (prior to productivity adjustment) utilized by Medicare in order to trend the base year per diem cost to the Medicaid rate period. This would include the use of the FY 2011, 2012 and 2013 Market Basket rates. To determine trended Medicaid nursing facility cost for each facility for the October 1, 2012 through September 30, 2013 demonstration period, the individual trended per diem cost rate is multiplied by the base year Medicaid incurred patient days which is obtained via MMIS.

(3) Total annual projected Medicaid nursing facility revenue of each facility for the October 1, 2012 through September 30, 2013 payment period is derived by taking the October 1, 2012 Medicaid rates of each nursing facility and multiplying this rate by the facility's SFY 2010 incurred Medicaid days.

(4) The Medicaid UPL compliance check is determined for this class by comparing the aggregate amounts as determined in step (2) above to ensure that projected Medicaid nursing facility cost is equal to or greater than projected Medicaid nursing facility rate expenditures in step (3). In the event that aggregate Medicaid nursing facility rate expenditures exceed aggregate Medicaid nursing facility cost, the Medicaid nursing facility rate for each facility will be limited to the Medicaid cost based rate as determined in (2) above.

L. Payment Assistance

The Medicaid Agency will pay each Provider of nursing care services, who furnishes the services in accordance with the requirements of the State Plan, the amount determined for services furnished by the Provider under the Plan according to the methods and standards set forth in Section III of this attachment.

M. Upper Limits

1. The Medicaid Agency will not pay more than the provider's customary charge for private-pay patients except governmental facilities that provide services free or at a nominal charge. These facilities will be reimbursed on a reasonable cost related basis.

2. Any limitation on coverage of cost published under 42 CFR 413.30 and 413.35 will be applied to payments for long-term care facility services.

Certified Public Expenditures Incurred in Providing Nursing Facility Services and Intermediate Care Facilities for the Individuals with Intellectual Disabilities (ICF/IID)Services to Medicaid Eligibles.

The South Carolina Medicaid Agency uses the South Carolina Department of Health and Human Services (SCDHHS) Financial and Statistical Report for Nursing Homes for its Medicaid Program and all state owned/operated governmental nursing facilities must submit this report each year. The Agency will utilize pages thirteen (Summary of Revenue and Expense) and six (Census data) to determine the allowable cost of nursing facility services provided to Medicaid eligibles to be certified as public expenditures (CPE) when CPE is used as the source of state matching funds. Hospice room and board expenditures will not be covered in the CPE analysis as these expenditures are funded via intergovernmental transfers from state agencies. The Agency will use the procedures outlined below:

I. Interim Reconciliation of Interim Medicaid Nursing Facility Payments for State Owned/Operated Governmental Nursing Facilities When CPE is Used as the Source of State Matching Funds:

Upon receipt of the state owned/operated nursing facility's fiscal year end June 30 cost report, each nursing facility's interim Medicaid fee for service rate payments and any supplemental payments that may had been made which applied to services provided during the cost reporting period will be reconciled to its SCDHHS Financial and Statistical Report for Nursing Homes as filed to the Medicaid Agency for the respective cost reporting period.

Effective for services provided on or after October 1, 2012, the State will determine each SCDMH nursing facility's allowable Medicaid per diem cost (routine and covered ancillary) by summing the nursing facility allowable Medicaid routine and covered ancillary service cost centers and dividing this amount by total nursing facility days. The allowable Medicaid routine service and covered ancillary service costs will be derived from page 13, Summary of Revenue and Expense. Total nursing facility days will be obtained from page six (Census data). Next, in order to determine the allowable Medicaid nursing facility per patient day costs, Medicaid routine and covered ancillary service costs will be summed and divided by actual census days to determine the allowable Medicaid per patient day costs. Therefore, to determine allowable Medicaid nursing facility costs for each state owned/operated governmental nursing facility, the allowable Medicaid per diem cost will be multiplied by the number of Medicaid nursing facility days served during the cost reporting period.

During the annual certified public expenditure reconciliation process, the allowable Medicaid nursing facility costs as determined above will be compared to Medicaid payments received and applicable(including both fee for service, gross adjustments, and patient responsibility payments (i.e. patient recurring income)) to services provided during the cost reporting period. The Medicaid days and payments are tied to MMIS paid claims data (including gross adjustment payment data). In the event of an underpayment, the Agency will make no further payment to the provider. In the event of an overpayment, the Agency will recover only the federal portion of the overpayment. Any difference to the reimbursement amount reflected above will be recorded as an adjustment on the CMS 64 report.

II. Final Reconciliation of Interim Medicaid Nursing Facility Payment Rate Post Reporting Year for State Owned/Operated Governmental Nursing Facilities When CPE is Used as the Source of State Matching Funds:

Upon issuance of a Final Audit Report by the Agency's audit contractor of the state owned/operated nursing facility cost reports, the Agency will determine each nursing facility's audited Medicaid allowable per diem cost by summing the nursing facility's routine service and covered ancillary service cost centers and dividing this amount by total nursing facility days. The routine service and covered ancillary service costs will be derived from the audited Summary of Revenue and Expense as reflected in the audit report. Total nursing facility days will represent audited census days as reflected in the audit report. Therefore, to determine each nursing facility's audited Medicaid nursing facility cost, the audited Medicaid per diem cost will be multiplied by Medicaid nursing facility days to determine the audited Medicaid nursing facility costs. The Medicaid days are tied to MMIS paid claims data. The Agency will compare the audited allowable Medicaid nursing facility costs against the Medicaid payments received and applicable (including fee for service, gross adjustments including CPE reconciliation adjustments, and patient responsibility payments (i.e. patient recurring income) to services provided during the cost reporting period. The Medicaid days and payments that will be used in the final audit settlement will be tied to MMIS paid claims (including gross adjustment payment data). In the event of an underpayment, the Agency will not make an additional payment. In the event of an overpayment, the Agency will recover only the federal portion of the overpayment. Any difference to the reimbursement amount reflected above will be recorded as an adjustment on the CMS 64 report.

III. Interim Reconciliation of Interim Medicaid Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) Payments When CPE is Used as the Source of State Matching Funds:

Upon receipt of the SCDDSN ICF/IID fiscal year end June 30 cost reports, each ICF/IID facility's interim Medicaid fee for service rate payments and any supplemental payments that may had been made which applied to services provided during the cost reporting period will be reconciled to its CMS Form 2552 cost report as filed to the Medicaid Agency for the respective cost reporting period.

The State will determine each of the SCDDSN ICF/IID's allowable Medicaid per diem cost by first identifying the allowable Medicaid routine cost and covered ancillary service costs included within the CMS Form 2552 cost report. This amount will be derived from the applicable lines for each provider as reflected on worksheet B, Part I, column 24. Each provider's patient days that will be used in the determination of the ICF/IID Medicaid per diem cost will be obtained from the Census data worksheets. Next, in order to determine each provider's allowable Medicaid cost, the Medicaid ICF/IID per diem cost will be multiplied by covered Medicaid ICF/IID days to determine allowable Medicaid ICF/IID costs.

During the annual certified public expenditure reconciliation process, each ICF/IID's allowable Medicaid costs as determined above will be compared to Medicaid payments received and applicable (including both fee for service, gross adjustments, and patient responsibility payments (i.e. patient recurring income) to services provided during the cost reporting period. In the event of an underpayment, the Agency will make no further payment to the provider. In the event of an overpayment, the Agency will recover only the federal portion of the overpayment. Any difference to the reimbursement amount reflected above will be recorded as an adjustment on the CMS 64 report.

Final Reconciliation of Interim Medicaid Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IIDs) Payment Rate Post Reporting Year When CPE is Used as the Source of State Matching Funds: Upon issuance of a Final Audit Report by the Agency's audit contractor of the SCDDSN ICF/IID cost reports, the Agency will determine each ICF/IID's audited Medicaid routine and covered ancillary service per diem cost by identifying the applicable line of the audited worksheet B, Part I, column 24 and dividing this amount by each ICF/IID's total patient days as identified from the audited Census data. To determine each ICF/IID's audited Medicaid cost, each ICF/IID's audited Medicaid per diem cost will be multiplied by covered Medicaid patient days to determine the audited Medicaid ICF/IID costs of each provider. The Medicaid days are tied to MMIS paid claims data. The Agency will then compare each ICF/IID's audited Medicaid costs against the Medicaid payments received and applicable (including both fee for service, gross adjustments including CPE reconciliation adjustments, and patient responsibility payments (i.e. patient recurring income) to services provided during the cost reporting period. The Medicaid days and payments, including claim and gross adjustment payments, that will be used in the final audit settlement will be tied to MMIS paid claims data. In the event of an underpayment, the Agency will not make an additional payment. In the event of an overpayment, the Agency will recover only the federal portion of the overpayment. Any difference to the reimbursement amount reflected above will be recorded as an adjustment on the CMS 64 report.