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State/Territory Name: South Carolina

State Plan Amendment (SPA) #: 14-0011

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS 179 Form
- 3) Approved SPA Pages

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

DEC 21 2017

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

RE: State Plan Amendment SC 14-0011

Dear Mr. Baker:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid state plan submitted under transmittal number (TN) 14-011. Effective May 1, 2014, this amendment modifies the State's reimbursement methodology for setting payment rates for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IIDs). Specifically, this amendment will establish a statewide average per diem rate for all ICF/IIDs based on the 2011 cost reports trended to the rate year 2014.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a), 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 May 1, 2014. 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

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL		1. TRANSMITTAL NUMBER: 14-011	2. STATE South Carolina
		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
FOR: HEALTH CARE FINANCING ADMINISTRATION		4. PROPOSED EFFECTIVE DATE May 1, 2014	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES			
5. TYPE OF PLAN MATERIAL (<i>Check One</i>):			
<input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN x <input checked="" type="checkbox"/> AMENDMENT			
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (<i>Separate Transmittal for each amendment</i>)			
6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR Subpart C		7. FEDERAL BUDGET IMPACT: a. FFY 2014 \$1.03 Million (4.38 million *.7057)*4/12 b. FFY 2015 \$3.09 million (\$4.38 million*.7064)	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-D, page 23 & 23a (new pages)		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (<i>If Applicable</i>): Attachment 4.19-D, Page 23	
10. SUBJECT OF AMENDMENT: Rebasing of ICF/IID Medicaid rates effective May 1, 2014			
11. GOVERNOR'S REVIEW (<i>Check One</i>):			
<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		x <input checked="" type="checkbox"/> OTHER, AS SPECIFIED: Mr. Keck was designated by 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 P.O. Box 8206 Columbia, South Carolina 29202-8206	
13. TYPED NAME: Anthony E. Keck			
14. TITLE: Director			
15. DATE SUBMITTED: June 26, 2014			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED: 06/30/14		18. DATE APPROVED: 12/21/2017	
PLAN APPROVED – ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: 05/01/14		20. SIGNATURE OF REGIONAL OFFICIAL: //s//	
21. TYPED NAME: Kristin Fan		22. TITLE: Director	
23. REMARKS:			

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 November 1, 2013, 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 2012 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 (November 1, 2013 - September 30, 2014), the agency will employ the use of a trend factor of 4.86% $((1.025 \times 1.023) - 1)$ based upon the use of the full CMS Skilled Nursing Facility PPS Market Based rate for fiscal years 2013 and 2014 (2.5% and 2.3%).

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 May 1, 2014, 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 2011 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 determined in accordance with the Provider Reimbursement Manual HIM-15.

- (1) First, 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.
- (2) Next, in order to trend the base year Medicaid per diem cost to the payment period (May 1, 2014 - September 30, 2014), the agency will employ the use of the midpoint to midpoint methodology and the use of the full CMS Skilled Nursing Facility PPS Market Based rate for fiscal year 2011 (2.3%).
- (3) Next, the ICF/IIDs are separated by class (institutional or community). The trended per diem cost of each ICF/IID within each class as determined in step (2) above is multiplied by the number of incurred SFY 2013 Medicaid patient days obtained via MMIS to determine the annual projected Medicaid cost of each ICF/IID for Medicaid rate setting purposes.
- (4) Finally, in order to determine a weighted average statewide rate for each class of ICF/IID facility (community and institutional), the aggregate Medicaid cost as determined in step (3) for each class is divided by the sum of the incurred SFY 2013 Medicaid patient days for each class to determine the statewide weighted average for each class.