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State/Territory Name: South Carolina

State Plan Amendment (SPA) #: 16-0003

This file contains the following documents in the order listed:

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

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
61 Forsyth Street S.W. Suite 4T20
Atlanta, Georgia 30303

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Atlanta Regional Operations Group

May 3, 2019

Mr. Joshua D. Baker
Director
SC Department of Health and Human Services
Post Office Box 8206
Columbia, South Carolina 29202-8206

Attention: Sheila Chavis

Re: South Carolina State Plan Amendment 16-0003

Dear Mr. Baker:

We have reviewed the proposed South Carolina State Plan Amendment, SC 16-0003, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on March 31, 2016. This amendment was submitted to comply with rates changes established under the final Medicare Hospice Rule published August 6, 2015 (CMS-1629-F). Specifically, the following changes are being made: (1) Changes the payment methodology for Routine Home Care (RHC) to implement two rates that will result in a higher base payment for the first 60 days of hospice care and a reduced base payment rate for days thereafter; (2) it establishes an add-on payment for services provided by a registered nurse or social worker during the last 7 days of the beneficiary's life; and also establishes Hospice cap amounts.

Based on the information provided, the Medicaid State Plan Amendment SC 16-0003 was approved on May 3, 2019. The effective date of this amendment is January 1, 2016. We are enclosing the approved HCFA-179 and a copy of the new state plan pages.

If you have any additional questions or need further assistance, please contact Cheryl Wigfall at (803) 252-7299 or Cheryl.wigfall@cms.hhs.gov.

Sincerely,

/s/

Shantrina D. Roberts, MSN
Deputy Director
Division of Medicaid Field Operations-South

Enclosures

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: 16-0003

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
January 1, 2016

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:
42 CFR, Part 447 – subchapter C

7. FEDERAL BUDGET IMPACT:
a. FFY 2016 $ 84,230
b. FFY 2017 $ 112,306

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-B pages 6.2, 6.3

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Attachment 4.19-B pages 6.2, 6.3

10. SUBJECT OF AMENDMENT: This State Plan Amendment reflects rate changes made under the final Medicare hospice rule published August 6, 2015; changes the payment methodology for Routine Home Care (RHC) to implement two rates that will result in a higher base payment for the first 60 days of hospice care and a reduced base payment rate for days thereafter and it also establishes an add-on payment for services provided by a registered nurse or social worker during the last seven days of a beneficiary's life.

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:
Mr. Soura was designated by the Governor to review and approve all State Plans

12. SIGNATURE OF STATE AGENCY OFFICIAL:
/s/

13. TYPED NAME:
Christian L. Soura

14. TITLE:
Director

15. DATE SUBMITTED:
March 31, 2016

16. RETURN TO:

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

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 03/31/16

18. DATE APPROVED:05/03/19

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
01/01/16

20. SIGNATURE OF REGIONAL OFFICIAL:
/s/

21. TYPED NAME: Shantrina D. Roberts

22. TITLE: Deputy Director
Division of Medicaid Field Operations-South

23. REMARKS:

17. Nurse Midwife Services:

Nurse Midwife Services are reimbursed at 100% of the Physician Services fee schedule rates effective for services provided on or after the implementation date as outlined in Physician Services methodology located at Attachment 4.19-B, Page 2a.2 Section 5. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers. The agency's fee schedule rate was set as of July 11, 2011 and is effective for services provided on or after that date. All rates are published on the agency's website at www.scdhhs.gov.

18. Hospice Services:

A. Payment Methodology

With the exception of payment for physician services, reimbursement for hospice services is made for one of the five levels of hospice services for each day in which an individual is under the care of the hospice provider:

(1) Routine Home Care of which there are two rates based upon the length of service-(a)Routine Home Care Days 1-60 and (b)Routine Home Care Days 61 and above.

(2) Continuous Home Care

(3) Inpatient Respite Care

(4) General Inpatient Care

(5) Service Intensity Add-On when the following criteria are met:

a) The day on which the services are provided is a Routine Home level of care; and

b) The day on which the service is provided occurs during the last seven days of life and the client is discharged deceased; and

c) The service is provided by a registered nurse or social worker that day for at least fifteen minutes and up to four hours total; and

d) The service is not provided by a social worker via telephone.

Billing instructions relating to the provision of each Hospice service described above are available via the SC Medicaid Hospice Provider Manual. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers. All rates are published on the agency's website at www.scdhhs.gov.

The Medicaid Agency will employ the use of the Medicaid Hospice payment rates published annually via the Centers for Medicare and Medicaid Services' (CMS) Medicaid Financial Management Group. The wage component of the daily hospice rates will be adjusted annually by the applicable annual Medicare Final Hospice Wage Index to reflect local geographical differences in the wage levels. Two sets of Medicaid Hospice payment rates will be established for each of the five hospice service rates to account for the hospice providers' compliance with the Medicare quality reporting requirements authorized under section 3004 of the Affordable Care Act. Failure by a Hospice provider to comply with the Medicare quality reporting requirements during each fiscal year will result in a two percent (2%) rate reduction applied prospectively to the following hospice rate year.

B. Cap on Overall Hospice Payment

The Medicaid Agency will limit overall aggregate payments made to each hospice during a hospice rate year using the following hospice cap periods:

Hospice Rate Year	Hospice Cap Period
2016	Jan. 1, 2016 – Oct. 31, 2016
2017	Nov. 1, 2016 – Oct. 31, 2017
2018	Nov. 1, 2017 – Oct. 31, 2018
2019 and After	Oct 1st – Sept. 30th

The total payment made for hospice services provided to Medicaid beneficiaries during the cap period will be compared to the cap amount applicable to the cap period as published by CMS. The hospice provider must refund any payments in excess of the cap. The hospice payment amount will be determined using dates of services for services provided during the year regardless of when the payment is actually made. For new hospice providers entering the Medicaid program after January 1, 2016, the initial cap calculation for newly certified hospice providers must cover a period of at least twelve (12) months but no more than twenty-three (23) months.

C. Limitations on Inpatient Care

Payments to a hospice for short-term inpatient care provided in a participating hospice inpatient unit, a participating hospital, or a nursing facility that additionally meets the special hospice standards regarding staffing and patient areas are subject to this limitation. Services provided in an inpatient setting must conform to the written plan of care. General inpatient care may be required for procedures necessary for pain control or acute or chronic symptom management which cannot be provided in other settings. Inpatient care may also be furnished to provide respite for the individual's family or other persons caring for the individual at home. Payments to a hospice for inpatient care must be limited according to the number of days of inpatient care furnished to Medicaid patients. During the 12 month period beginning November 1st of each year and ending October 31st, the aggregate number of the inpatient days (both for general inpatient care and inpatient respite care) may not exceed twenty (20) percent of the aggregate total number of days hospice care provided to all Medicaid recipients during that same period. The limitation calculation is determined in accordance with the requirements of 42 CFR 418.302(f).

D. Medicaid Recipients Receiving Hospice Services in Nursing Facilities

In addition to the five reimbursement rates of the services described in section 18(A), Hospice providers are also required to reimburse nursing facilities and Intermediate Care Facilities for individuals with Intellectual Disabilities (ICF/IID) for the Hospice Room and Board per diem. The Hospice Agency will bill Medicaid for the room and board provided to Medicaid beneficiaries who elect hospice and who continue to reside in nursing facilities or ICF/IIDs. Effective for room and board services provided on and after October 1, 2008, the Hospice Agency will receive 98% of the Medicaid nursing facility per diem rate. Effective for services provided on and after July 11, 2011, the Hospice Agency will receive 95% of the Medicaid nursing facility per diem rate. Upon receipt of the Medicaid reimbursement, the Hospice Agencies will reimburse the facility in which the Medicaid beneficiary resides.