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State/Territory Name: South Carolina

State Plan Amendment (SPA) #: 17-0017

This file contains the following documents in the order listed:

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

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

CENTERS FOR MEIJICARE & MEIJICAIU Services
CENTER FOR MEDICAID & CHIP SERVICES

Financial Management Group

MAR 14 2018

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

RE: State Plan Amendment SC 17-0017

Dear Mr. Baker:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid state plan submitted under transmittal number (TN) 17-017. Effective October 1, 2017, this amendment modifies the State's reimbursement methodology for setting payment rates for Nursing Facilities. Specifically, the amendment provides for a rate increase for state owned government nursing facilities. The increase will be based on the fiscal year ending 2015 cost reports trended to the mid-point of the rate year 2018.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a), 1902(a)(l 3), 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, 2017. 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: 17-0017

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, 2017

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, 447 Subpart C

7. FEDERAL BUDGET IMPACT:
a. FFY 2018 $400,000
b. FFY 2019 Rates will be rebased

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19- D, page 23

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Attachment 4.19-D, page 23

10. SUBJECT OF AMENDMENT:
State-Owned Nursing Facility Rate Updates Effective October 1, 2017

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. Baker was designated by the Governor to review and approve all State Plans

12. SIGNATURE OF STATE AGENCY OFFICIAL:
//s//

13. TYPED NAME:
Joshua D. Baker

14. TITLE:
Interim Director

15. DATE SUBMITTED:
December 19, 2017

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:
12/28/17

18. DATE APPROVED: 03/14/18

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
10/01/17

20. SIGNATURE OF REGIONAL OFFICIAL:
//s//

21. TYPED NAME:
Kristin Fan

22. TITLE:
Director, FMG

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 October 1, 2017, 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 2015 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 8.185% based upon the first quarter 2017 Global Insight Indexes 2014 Based 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 July 1, 2017, 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 2012 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.