

## **Table of Contents**

**State/Territory Name: South Carolina**

**State Plan Amendment (SPA) #: 18-0001**

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



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**Financial Management Group**

**June 11, 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 18-0001

Dear Mr. Baker:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid state plan submitted under transmittal number (TN) 18-001. Effective January 1, 2018 this plan amendment provides for the following: adding one private nursing facility to receive a supplemental payment to cover the cost of a mandatory evacuation of patient due to a hurricane; add coverage of Non-Emergence Medical Transportation (NEMT) to nursing facility services; provide an add-on to the per diem rate to pay for the NEMT services; and eliminate the occupancy required for replacement facilities for the first six months of operations.

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 January 1, 2018. 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

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b>	1. TRANSMITTAL NUMBER: 18-0001	2. STATE South Carolina
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
<b>FOR: HEALTH CARE FINANCING ADMINISTRATION</b>		
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE January 1, 2018	

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 440.170(a)	7. FEDERAL BUDGET IMPACT: a. FFY 2018    \$ 1,971,750 b. FFY 2019    \$ 2,629,000
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:  Attachment 3.1-A Limitation Supplement, page 9d Attachment 4.19-D, pages 14, 18, 20, & 26b	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT ( <i>If Applicable</i> ):  Attachment 3.1-A Limitation Supplement, page 9d Attachment 4.19-D, pages 14, 18, 20, & 26b

10. SUBJECT OF AMENDMENT:

This plan amendment updates the October 1, 2017 Medicaid Nursing Facility reimbursement rates to take into account the incurred costs of providing Non-Emergency Medical Transportation (NEMT) Services effective January 1, 2018.

11. GOVERNOR'S REVIEW (*Check One*):

GOVERNOR'S OFFICE REPORTED NO COMMENT                       OTHER, AS SPECIFIED:  
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED                      Mr. Baker was designated by the Governor  
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL                      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: Joshua D. Baker	
14. TITLE: Director	
15. DATE SUBMITTED: March 16, 2018	

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED: 03/26/18	18. DATE APPROVED: 06/11/18
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: 01/01/18	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 changed to read: Attachment 3.1-A page 9a.6; Attachment 3.1-D page 3; Attachment 3.1-A Limitation Supplement page 9d; and Attachment 4.19-D pages 14, 18, 20, and 26b.

Block #9 changed to read: Attachment 3.1-A page 9a.6; Attachment 3.1-D page 3; Attachment 3.1-A Limitation Supplement page 9d; and Attachment 4.19-D pages 14, 18, 20, and 26b.

**Nursing Home Non-Emergency Medical Transportation**

Non-emergency medical transportation (NEMT) for nursing home residents is a Medicaid covered service that is delivered outside of the NEMT Broker program.

**Access to Non-Emergency Transportation for Dual Eligible Beneficiaries Receiving Medicare Part D Outpatient Drugs**

Transportation to and from a pharmacy to obtain Part D prescription drugs is covered for full benefit dual eligible beneficiaries and is provided through the Broker. No transportation to and from a pharmacy is available when the pharmacy delivers or can provide medications by mail order.

**Coverage of Meals, Lodging and Escorts:**

In-state and out-of-state services for transportation, lodging and meals for members and escorts related to covered services shall be limited to prior approved arrangements and reimbursement as determined to be appropriate by the Broker of SCDHHS. When the State, in its sole discretion, determines it to be efficient, cost effective and medically necessary, an escort may accompany the recipient to and from covered medical services. The Broker will make a case-by-case determination of the type of lodging arrangements and amount of reimbursement as may be appropriate for in-state lodging and meals for beneficiaries and escorts.

**B. Special Needs Transportation**

Special Needs transportation services is a Medicaid covered service that is delivered outside of the NEMT Broker program. State agencies provide special needs transportation to designated populations under contract with SCDHHS. Identified state agencies that provide this transportation are the School for the Deaf and Blind, the Department of Social Services, Continuum of Care and the Department of Education. The special needs populations approved for these services are generally comprised of unescorted children, consumers of some mental health and therapeutic services and other special Medicaid eligible members with unique transportation needs. Transports are generally provided for Medicaid eligible members to mental health or behavioral treatment services at community-based providers. Special needs transportation services are covered by Medicaid as fee-for-service, regardless of the member's enrollment in a Managed Care Organization (MCO).

**C. ADULT DAY HEALTHCARE TRANSPORTATION UNDER 15 MILES**

NET broker services are not furnished for beneficiary transport to an Adult Day Health Care center within an exclusion zone of 15 mile radius of an Adult Day Health Care facility. Beneficiary transport within the 15 mile zone is the responsibility of the Adult Day Health Care provider. The cost of Beneficiary transportation to Adult Day Health Care services within the 15 mile radius of the facility is the responsibility of the Adult Day Health Care Provider.

**D. Nursing Home Non-Emergency Medical Transportation**

Non-emergency medical transportation (NEMT) for nursing home residents is a Medicaid covered service that is delivered outside of the NEMT Broker program. Nursing homes are responsible for arranging and paying for all NEMT transportation costs for their residents. Nursing home rates contain a NEMT component, allowing nursing homes to obtain NEMT services for their residents from any qualified transportation provider, as defined by the South Carolina Office of Regulatory Staff and the South Carolina Department of Health and Environmental Control.

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SUPERSEDES: SC 17-0002

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SUPERSEDES: SC 17-0002

PROVIDER NAME: 0  
 PROVIDER NUMBER: 0  
 REPORTING PERIOD: 10/01/15 through 09/30/16 DATE EFF. 01/01/18

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 @ 0.90 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	2.90%			0.00
COST OF CAPITAL				0.00
PROFIT INCENTIVE (MAX 3.5% OF ALLOWABLE COST)			3.50%	0.00
COST INCENTIVE - FOR GENERAL SERVICE, DIETARY, LHM				0.00
EFFECT OF \$1.75 CAP ON COST/PROFIT INCENTIVES			\$1.75	0.00
SUBTOTAL				0.00
NON-EMERGENCY MEDICAL TRANSPORTATION (NEMT) ADD-ON				0.00
ADJUSTMENT FACTOR		0.0000%		0.00
REIMBURSEMENT RATE				0.00

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SUPERSEDES: SC 17-0016

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. The Medicaid Agency developed a facility specific Non-Emergency Medical Transportation (NEMT) Add-On based upon the use of the SC NEMT Broker (i.e. Logisticare) calendar year (CY) 2016 trip and mileage data for ambulatory transports, wheelchair transports, advanced life support transports, and stretcher/basic life support transports. Medicaid agency developed fee schedule rates for the types of transports reflected above were applied to the number of one way trips and mileage logged for each type of transport trip as reflected in the CY 2016 Logisticare data. The Medicaid NEMT transport costs of each nursing facility were summed and then divided by each nursing facility's Medicaid patient days reflected within the 2016 cost report used to establish the October 1, 2017 Medicaid rate to determine the January 1, 2018 NEMT Add-On per diem. In the event that a less than full year cost report was used to establish an October 1, 2017 nursing facility Medicaid rate then the Medicaid days were annualized for this computation. In the event that a provider can support and justify major discrepancies noted between provider data and Logisticare data for CY 2016, the Medicaid Agency shall make adjustments to the NEMT Add-On rate.
11. The Medicaid reimbursement rate will be the total of costs accumulated in step 6, cost of capital, cost incentive/profit, and NEMT Add-On per diem.

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<sup>th</sup>) 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

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SUPERSEDES: SC 14-020



Facilities that decertify and recertify nursing facility beds that results in a change in its bed capacity by more than fifty percent (50%) will not be entitled to a new budget.

2. Payment determination for a replacement facility:

The following methodology shall be utilized to determine the rate to be paid to a replacement facility:

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 through the last day of the sixth (6<sup>th</sup>) 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 as described in Section III C of this plan, with the exception of inflation and the application of minimum occupancy requirements. No inflation adjustment will be made to the interim rates for the first six (6) months cost and actual patient days will be used for the initial six (6) month rate period.

Within (90) days after the end of the first full six (6) calendar months of operation, the provider will submit to the Medicaid Agency a Uniform Financial and Statistical Report covering the period through the first full six (6) calendar months of operation. However, a thirty (30) day extension of the due date of the cost report may be granted for good cause. To request an extension, a written request should be submitted to the Division of Long Term Care Reimbursements prior to the cost report due date.

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SUPERSEDES: SC 14-020

- (7) The annual Medicaid cost based rate expenditures and the annual Medicaid rate expenditures for all providers within the class are summed to determine the aggregate payments for each class.
- (8) The Medicaid UPL compliance check is determined by comparing the aggregate amounts as determined in (7) above to ensure that Medicaid cost based rate expenditures are equal to or greater than Medicaid rate expenditures. In the event that aggregate Medicaid rate expenditures exceed aggregate Medicaid cost based rate expenditures, the Medicaid rate for each facility will be limited to the Medicaid cost based rate as determined in (5) above.
- (9) Due to the mandatory evacuation ordered by Governor Haley of South Carolina in regards to Hurricane Matthew, the following nursing facilities will receive quarterly private nursing facility UPL payments equating to Medicaid's share of its allowable Medicaid reimbursable evacuation related costs. In the determination of allowable Medicaid reimbursable evacuation costs, any insurance proceeds received by the impacted nursing facilities that relate to the residents' evacuation must be offset against the evacuation costs claimed for payment. The nursing facilities that qualify for this UPL payment are as follows:

First Group Effective October 1, 2017: Heartland of West Ashley, Johns Island Rehab and Healthcare, Life Care Center of Charleston, Mount Pleasant Manor, Riverside Health and Rehab, Sandpiper Rehab and Nursing, White Oak Manor - Charleston, Bayview, Life Care Center of Hilton Head, NHC of Bluffton, Hallmark Healthcare, Oakbrook Health and Rehab, Heartland Healthcare of Charleston (Hanahan) and Prince George.

Second Group Effective January 1, 2018: Blue Ridge in Georgetown.

The sum of the private UPL payments will not exceed the upper payment limit calculated under the FFY 2018 private nursing facility UPL demonstration.

## II. Non-State Owned Governmental Nursing Facility

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

The three most recent quarterly nursing facility UPL payments paid during the preceding federal fiscal year serves as the base data used for the annual Medicaid UPL demonstration for this ownership class and is described below:

- (1) Calculated Medicare upper payment limits for the December, March, and June quarters of the preceding federal fiscal year are determined in accordance with the Essential Public Safety Net Nursing Facility Payment Program as described in Section III(K) of Attachment 4.19-D. Additionally, the Medicaid paid days associated with each quarter are identified via MMIS and exclude hospice days.

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SUPERSEDES: SC 17-0016