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

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Centers for Medicaid, CHIP, and Survey & Certification

Mr. Anthony E. Keck
Director
Department of Health and Human Services
P.O. Box 8206
Columbia, South Carolina 29202-8206

JUN 2 9 2011

RECEIVED

JUL 07 2011

Department of Health & Human Services
OFFICE OF THE DIRECTOR

RE: State Plan Amendment SC 11-006

Dear Mr. Keck:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 11-006. Effective April 8, 2011 this amendment proposes to revise the nursing facility payment methodology. Specifically, payment rates for dates of service on or after April 8, 2011 will be reduced to ninety seven percent (97%) of the rates in effect on October 1, 2010.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a), 1902(a)(13), 1902(a)(30), 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 April 8, 2011. 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

Cindy Mann
Director, CMCS

Cc: Mark Cooley, NIRT
Venesa Day, NIRT
Tim Weidler, NIRT

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 11-006

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
04/08/11

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 Subpart C

7. FEDERAL BUDGET IMPACT: FMAP
a. FFY 2011 $(5,637,650)
b. FFY 2012 $(13,205,120)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-D, pages 13, 14, 18, 19, 25 and 40

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Attachment 4.19-D, pages 13, 14, 18, 19, 25 and 40

10. SUBJECT OF AMENDMENT:
Nursing facility payment reductions effective April 8, 2011.

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

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Anthony E. Keck

14. TITLE:
Director

15. DATE SUBMITTED:
April 7, 2011

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:

18. DATE APPROVED:
06-29-11

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
APR - 8 2011

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
William Lasowski

22. TITLE:
Deputy Director, CMCS

23. REMARKS:

A. REIMBURSEMENT METHODOLOGY TO BE USED IN THE CALCULATION OF THE MEDICAID REIMBURSEMENT RATES

A prospective rate shall be established for each nursing facility separately based on the facility's cost report, and upon the standard costs which are developed in accordance with the methodology described below. In the event that audit adjustments are made to cost reports in accordance with Title XIX and Title XVIII Program rules, regulations, policies and procedures, the rate of payment will be established so as to be consistent with the facility's cost as audited. In the event that such adjustment is made subsequent to the date that a facility was paid an incorrect rate based on unaudited costs, the facility will be liable to repay to the South Carolina Department of Health and Human Services the difference between the audited rate and the interim rate for the contract period. In a case in which an audited rate exceeds the interim rate, the South Carolina Department of Health and Human Services will be liable to repay the facility the difference between the audited rate and the interim rate for the contract periods beginning on or after October 1, 1994.

Effective October 1, 2010, nursing facilities which do not incur an annual Medicaid utilization in excess of 3,000 patient days will receive a prospective payment rate which will represent the weighted average industry rate at the beginning of each rate cycle. Effective for services provided on and after April 8, 2011, these nursing facilities will receive ninety-seven percent (97%) of the October 1, 2010 weighted average industry rate. This rate will not be subject to change as a result of any field audit, but will be subject to change based on the lower of cost or charges test to ensure compliance with the state plan.

Minimum occupancy levels of 96% are currently being utilized for Medicaid rate setting purposes. Effective on and after October 1, 2003, Medicaid rates for nursing facilities located in counties where the county occupancy rate is less than 90% based upon the FYE September 30 cost report information will be established using the following policy:

- The SCDHHS will waive the 96% minimum occupancy requirement used for rate setting purposes for those nursing facilities located in counties whose occupancy is less than 90%. However, standards will remain at the 96% minimum occupancy level.
- The SCDHHS will calculate the affected nursing facilities' Medicaid reimbursement rate based upon the greater of the nursing facility's actual occupancy or the average of the county where the nursing facility is located.
- In those counties where there is only one contracting nursing facility in the county, the nursing facility Medicaid reimbursement rate will be based upon the greater of the nursing facility's actual occupancy or 85%.

1

PROVIDER NAME:	0				
PROVIDER NUMBER:	0				
REPORTING PERIOD:	10/01/08	through	09/30/09	DATE EFF.	04/08/11

		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 @	0.96	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 2.00%				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
REIMBURSEMENT RATE UNDER OCTOBER 1, 2010 METHODOLOGY				0.00
REIMBURSEMENT RATE @ 97% OF OCT. 1, 2010 METHODOLOGY				0.0

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.

0. For rates effective October 1, 2010, the provider's reimbursement rate under this concept will be the total of costs accumulated in step 6, cost of capital, cost incentive and profit.

11. For rates effective for services provided on and after April 8, 2011, the provider's reimbursement rate will equal to 97% of the rate calculated in step 10.

D. 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. Effective for transactions occurring on and after April 8, 2011, nursing facilities that qualify for a new facility rate via 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 will receive 97% of the rate calculated in accordance with the October 1, 2010 reimbursement methodology.

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^{th}) 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

except that all standards to be used will be one hundred twenty percent (120%) of the standards for the size of facility to adjust for lower initial occupancy. The one hundred twenty percent (120%) adjustment is determined by considering the average eighty percent (80%) occupancy for the first six (6) months of operation of a new facility versus the minimum of ninety-six percent (96%) occupancy required for all facilities that have been in operation for more than six (6) months. Within ninety (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.

This report will be used to determine allowable reimbursement of the provider for the initial rate cycle. A new prospective rate, based upon the Uniform Financial and Statistical Report, will be determined using the methodology as previously stated in Section III C of this plan except for the following methodology:

a) Payment for the first six months will be retrospectively adjusted to actual costs not to exceed 120% of the standards and actual occupancy.

b) No inflation adjustment will be made to the first six (6) months cost.

c) Effective on the first (1^{st}) day of the seventh (7^{th}) month of operation through the September 30 rate, the per diem costs effective July 1, 1994 will be adjusted to reflect the higher of:

   1. Actual occupancy of the provider at the last month of the initial cost report; or

   2. 90% occupancy.

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.

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/MR 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. Intermediate Care Facilities for the Mentally Retarded (ICF/MRs) owned by the South Carolina Department of Disabilities and Special Needs (SCDDSN) and deemed eligible to certify by the State will be reimbursed on Medicaid costs, based on certification by the facilities of their allowable Medicaid costs of providing ICF/MR care via the submission of annual Medicaid cost reports. An interim per diem rate will be established based upon the SCDHHS review of each facility's most recently filed desk reviewed/cost settled Medicare 2552 report along with budgeted cost report information supplied by the SCDDSN. After the filed Medicare 2552 report for the payment period for which the interim rate was paid has been received, the interim rate will be reconciled to actual allowable Medicaid costs. Upon final settlement of the 2552 report, the difference between the final and interim allowable Medicaid costs will be an adjustment(s) to the applicable period for which the allowable Medicaid cost was incurred and initial claim was made.

5. 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.

Effective for services provided on and after April 8, 2011, the swing be rate will equal 97% of the October 1, 2010 swing bed rate.

I. Intensive Technical Services Reimbursement

Effective December 1, 2008, an enhanced rate of $364.00 per patient day will be available for nursing facility level of care recipients who require more intensive technical services (i.e., those recipients who have extreme medical conditions which requires total dependence on a life support system). Effective for services provided on and after April 8, 2011, the enhanced rate will be $353.08. In order to develop this rate, the SCDHHS reviewed budgeted cost information relating to the

insurance test while those not specifically identified will be considered an administrative cost. In the event that the provider does not meet all of the "self-insurance" criteria as established in HIM-15, section 2162.7, the provider's allowable Medicaid reimbursable costs associated with insurance coverage will be limited to one of the following options:

a) actual claims paid during the cost reporting period; or

b) actual claims paid with a year end accrual for incurred but not reported (IBNR) expenses applicable to the cost reporting period. The IBNR factor will be determined based upon experience occurring during the three month period immediately following the end of the cost reporting period.

Allowability of actual loses related to deductibles or co-insurance will be determined in accordance with HIM-15, Section 2162.5.

Professional Liability Expense Only - Pool Payments

Effective October 1, 2007, providers will be reimbursed outside of their Medicaid reimbursement rate for Professional Liability claims that exceed $50,000 on an individual claim-by-claim basis. When a claim for payment is made under this provision, the provider will be required to submit to the SCDHHS a copy of the final settlement agreement and/or court or jury decision. Any settlement negotiated by the provider or award resulting from a court or jury decision of damages paid by the provider in excess of the provider's policy, as well as the reasonable cost of any legal assistance connected with the settlement or award will be considered an allowable Medicaid reimbursable cost, provided the provider submits evidence to the satisfaction of the SCDHHS and/or the SAO that the insurance coverage carried by the provider at the time of the loss reflected the decision of prudent management (HIM-15, section 2160.2).The reasonable legal costs associated with this claim will be reimbursed via the nursing facility's Medicaid per diem rate.

This payment will be made via a gross adjustment and Medicaid's portion of this payment will be determined based upon the Medicaid occupancy of the nursing facility during the cost-reporting period in which the claim is paid. Effective for professional liability claim payments made on and after April 8, 2011, only 97% of the Medicaid allowed amount will be paid. Payments made under this method will be for those claims that have a final settlement date within the corresponding cost reporting period. For example, claims with a final settlement date occurring between October 1, 2005 through September 30, 2006 will be eligible for payment on or after October 1, 2007. The final settlement between the plaintiff and the nursing facility should indicate the amount of the payment for compensatory or actual damages and the amount of the payment for punitive damages. Professional liability punitive damage awards are not considered an allowable cost for South Carolina Medicaid reimbursement purposes. This payment will not be subject to the lower of cost or charges compliance test.