

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

OCT 15 2015

RECEIVED

OCT 21 2015

Mr. Christian L. Soura
Interim Director
Department of Health and Human Services
P.O. Box 8206
Columbia, South Carolina 29202-8206

Department of Health & Human Services
OFFICE OF THE DIRECTOR

RE: State Plan Amendment SC 15-008

Dear Mr. Soura:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid state plan submitted under transmittal number (TN) 15-008. Effective October 1, 2015 this amendment modifies the state's reimbursement methodology for setting payment rates for nursing facility services. Specifically, this amendment updates the deemed asset value and market rate of return used in the determination of the fair rental value rates and updates the per diem rates for routine care by 3%.

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 October 1, 2015. 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,


Timothy Hill
Director

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL		1. TRANSMITTAL NUMBER: SC 15-008	2. STATE South Carolina
FOR: HEALTH CARE FINANCING ADMINISTRATION		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, 2015	
5. TYPE OF PLAN MATERIAL (Check One): <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT			
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR, Subpart C		7. FEDERAL BUDGET IMPACT: (\$23.20 million x 70.64%) a. FFY 2016 <.711 Million> b. FFY 2017 \$Rates will be rebased	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-D, pages 6, 8, 14, 15, 16, 17, 26, 27, 32, & 34		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Attachment 4.19-D, pages 6, 8, 14, 15, 16, 17, 26, 27, 32, & 34	
10. SUBJECT OF AMENDMENT: Nursing Facility Rate Updates Effective October 1, 2015			
11. GOVERNOR'S REVIEW (Check One): <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input checked="" type="checkbox"/> OTHER, AS SPECIFIED: <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED Mr. Soura was designated by the Governor to <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL review and approval all state plans.			
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		16. RETURN TO: South Carolina Department of Health and Human Services P.O. Box 8206 Columbia, South Carolina 29202-8206	
13. TYPED NAME: Christian L. Soura			
14. TITLE: Director			
15. DATE SUBMITTED: August 14, 2015			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED:		18. DATE APPROVED: OCT 15 2015	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: OCT 01 2015		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: Justin Fan		22. TITLE: Deputy Director, FIMG	
23. REMARKS:			

Since the return on capital payment is provided as an incentive for the expansion of Medicaid services by the private sector, only those facilities that were established as profit earning centers were selected for the calculation of the base period costs. Non-profit facilities were excluded from the base period calculation.

2) Inflation Adjustment To Current Period "Deemed Asset Value"

The plan uses the index for the rental value of a home computed as part of the CPI as the appropriate measure for approximating the increase in the value of nursing home assets in South Carolina since 1980-1981. This index measures the increase in the amount that homeowners on average could get for renting their homes. For the period from 1980-1981 through the federal cost year 2013-2014, this index rose 234.857 percent.

Inflating the base period market value of \$15,618 by the index for homeowner's rent, the "Deemed Asset Value" for cost year 2013-2014 is \$52,298 per bed and will be used in the determination of nursing facility rates beginning October 1, 2015.

3) Calculation of "Deemed Depreciated Value"

The plan will exclude depreciation payments already received by operators from the Deemed Asset Value on the theory that the depreciation charges represent a reasonable valuation of the decline in the worth of the assets from old age. The result is the "Deemed Depreciated Value."

For a facility existing prior to July 1, 1989, the plan will continue to reimburse for actual depreciation costs based on a straight line apportionment of the original cost of the facility and the actual value of any additions. Effective October 1, 1990, for new facilities established or new beds entering the Medicaid Program on and after July 1, 1989, depreciation payments will be set based on actual construction costs, or the Deemed Asset Value when the facility begins operations, whichever is lower, and on applicable Medicare guidelines for depreciation. However, building depreciation for all new facilities/new beds on line on or after July 1, 1991 will be assigned a useful life of 40 years. Accumulated depreciation to be used to offset the deemed asset value for new facilities will be based on accumulated allowed depreciation (i.e. the lesser of actual depreciation or that determined by the Deemed Asset Value).

For bed increases of less than 50% (i.e. no six months cost report is filed), recognition of capital costs will be made at the point in time these beds are certified for Medicaid participation. For clarification, the Deemed Asset Value in effect at the time the beds are certified for Medicaid

The plan sets the rate of return for a fiscal year at the average of rates for thirty year Treasury bonds for the latest three completed calendar years prior to the fiscal year, as determined by the Division of Research and Statistics of the Budget and Control Board, based on latest data published by the Federal Reserve. Effective October 1, 2015, this rate is 3.00%.

Acknowledging a newly constructed facility's plight of high per bed construction costs and interest rates as great and greater than the market rate of return, the rate of return for these facilities will be the greater of the interest rate incurred by the facility or the industry market rate of return as determined by the Budget and Control Board. These facilities will only be allowed their interest rate (if greater) during a transition period which is defined as the rate period beginning with the facility's entrance into the Medicaid program and ending at that point in time in which the facility files its first annual FYE September 30 cost report that will be used to establish the October 1 rate (i.e. period ends September 30). In no circumstances will the allowed interest rate exceed 3% above the industry market rate of return.

5) Additions To Facilities After 1981

The plan intends to provide adequate incentives for the expansion of nursing home services by the private sector of the state. The Deemed Depreciated Value takes into account the wearing out of facilities, but does not include any factor for additions or upgradings to the facilities. Operators who have made capital improvements to their facilities since 1981 are permitted to add the amount of the investment to their Deemed Asset Value. Operators are also permitted to add the cost of future additions and upgradings of facilities to their Deemed Asset Value. This provision will provide an incentive to operators to reinvest part of their cash flow back into the facility to maintain and improve the level of service provided by the operator. For clarification purposes, capital expenditures incurred by new beds on line on or after July 1, 1989 during the initial cost reporting period will not be considered as improvements, but as part of actual construction costs.

6) Computation of Cost of Capital

The cost of capital for each patient day served would be calculated for each nursing home based on the Deemed Asset Value. The computation of the rate of reimbursement for the cost of capital is illustrated below in Table 1 for the

PROVIDER NAME: 0
PROVIDER NUMBER: 0
REPORTING PERIOD: 10/01/13 through 09/30/14 DATE EFF. 10/01/15

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 @ 0.92 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	3.00%			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
SUBTOTAL				0.00
ADJUSTMENT FACTOR		0.0000%		0.00
REIMBURSEMENT RATE				0.00

Effective October 1, 1995, for the purpose of establishing all cost center standards, the facilities are grouped according to bed size. The bed groupings are:

- 0 Through 60 Beds
- 61 Through 99 Beds
- 100 Plus Beds

B. ALL STANDARDS, EXCEPT FOR GENERAL SERVICES, FOR PROPRIETARY AND NONPROFIT FACILITIES (EXCLUDING STATE OWNED) WILL BE COMPUTED USING PROPRIETARY FACILITIES ONLY. EFFECTIVE OCTOBER 1, 1997, HOSPITAL BASED PROPRIETARY NURSING FACILITIES WILL BE EXCLUDED FROM THE COMPUTATION OF ALL STANDARDS, EXCEPT FOR GENERAL SERVICES. THE GENERAL SERVICE STANDARD WILL BE COMPUTED USING PROPRIETARY AND NONPROFIT FACILITIES (EXCLUDING STATE OWNED). A BRIEF DESCRIPTION ON THE CALCULATION OF ALL THE STANDARDS IS AS FOLLOWS:

1. General Services:

- a. Accumulate all allowable cost for the General Services cost center (Nursing & Restorative) for all facilities in each bed size.
- b. Determine total patient days by multiplying total beds for all facilities in each group by (365 x 92%).
- c. Calculate the mean cost per patient day by dividing total cost in (a) by total patient days in (b).
- d. Calculate the standard by multiplying the mean by 105%.
- e. The establishment of the General Services standard for all nursing facilities (excluding state owned facilities) will be based on the average of the percentage of Medicaid Level A patients/total Medicaid patients served. Rates effective on or after October 1, 2000 will be computed annually using nursing facility utilization (including nursing facility days paid under the Hospice Benefit) by patient acuity based upon the preceding July 1 through June 30 data period. Effective October 1, 2003, co-insurance days for dual eligibles are excluded from the computation. Effective December 31, 2011, nursing facility providers will no longer be allowed to appeal its acuity level (i.e. percent skilled) payment adjustment determination for any current or future year payment rates. The General Services standard for each separate facility will be determined in relation to the percent of Level A Medicaid patients served, i.e., the base standard determination in (d.) above will be decreased as the percent of Level A Medicaid patients is decreased and increased as the percent of Level A Medicaid patients is increased.

2. Dietary; Laundry, Maintenance and Housekeeping; Administration and Medical Records & Services: The standard for each of these three cost categories is calculated as follows:
 - a. Accumulate all allowable cost for each cost center for all facilities in each bed size.
 - b. Determine total patient days by multiplying total beds for all facilities in each group by (365 x 92%).
 - c. Calculate the mean cost per patient day by dividing total cost in (a) by total patient days in (b).
 - d. Calculate the standard by multiplying the mean by 105%.

C. RATE COMPUTATION:

Rates will be computed using the attached rate computation sheet (see page 14) as follows:

1. For each facility, determine allowable cost for the following categories:

COST SUBJECT TO STANDARDS:

General Services
Dietary
Laundry, Maintenance and Housekeeping
Administration and Medical Records & Services

COST NOT SUBJECT TO STANDARDS:

Utilities
Special Services
Medical Supplies
Property Taxes and Insurance Coverage - Building and Equipment
Legal Fees

2. Calculate actual allowable cost per day based on the cost reports for each category by dividing allowable cost by actual days. If the facility has less than 92% occupancy, actual days will be adjusted to reflect 92% occupancy.
3. For cost subject to standards, the lower of cost determined in step 2 or the cost standard will be allowed in determining the facility's rates. Effective October 1, 1997, the General Services, Dietary, and Laundry, Housekeeping, and Maintenance cost centers are combined. Therefore, compare the sum of the allowable cost of these three cost centers to the sum of these three cost standards.

4. For costs not subject to standards, the cost determined in step 2 will be allowed in determining the facility's rate.
5. Accumulate costs determined in steps 3 and 4.
6. Inflate the cost in step 5 by multiplying the cost in step 5, by the inflation factor. The maximum inflation factor that can be used will be that provided by the State of South Carolina Division of Research and Statistical Services and is determined as follows:
 - a. Proxy indices for each of the eleven major expenditure components of nursing homes, (salaries, food, medical supplies, etc.) during the third quarter of 2015 were weighted by the expenditure weights of the long term care facilities. These eleven weighted indices are summed to one total proxy index for the third quarter of 2015.
 - b. Proxy indices are estimated for each of the eleven major expenditure components of nursing homes, (salaries, food, medical supplies, etc.), during the third quarter of 2016 and then weighted by the same expenditure weights as in step a. These weighted proxy indices were summed to one total proxy index for the third quarter of 2016.
 - c. The percent change in the total proxy index during the third quarter of 2015 (as calculated in step a), to the total proxy index in the third quarter of 2016 (as calculated in step b), was 3.00%. Effective October 1, 2015 the inflation factor used was 3.00%.
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7. The per patient day cost of capital will be calculated by dividing capital cost as determined under I.(F)(c) of this plan by actual patient days. However, if the facility has less than 92% occupancy, actual days will be adjusted to reflect 92% occupancy.
8. Cost Incentive - General Services, Dietary, and Laundry, Housekeeping, and Maintenance

If the facility's actual allowable costs for these three cost centers are below the sum of these three allowable cost standards, the facility will be eligible for a cost incentive of an amount equal to the difference between the sum of the standards and the sum of the facility's actual costs, up to 7% of the sum of the standards.
9. Profit will be allowed if the provider's allowable cost is lower than the standard as follows:
 - a. Administration and Medical Records & Services - 100% of difference with no limitation.

J. Payment for Out-of-State Long Term Care Facilities

In order to provide services to the South Carolina Medicaid patients awaiting placement into a nursing facility, the agency will contract with out-of-state facilities at the other states' Medicaid reimbursement rate. The agency will use the out-of-state facility's survey conducted by their survey and certification agency for our survey and certification purposes. Placement of a South Carolina Medicaid recipient into an out-of-state facility will only occur if a bed is unavailable in South Carolina. No year end South Carolina Medicaid long term care cost report will be required from the participating out-of-state facilities.

K. Upper Payment Limit Calculation

I. Private Nursing Facility Services

The following methodology is used to estimate the upper payment limit applicable to privately owned or operated nursing facilities (i.e. for profit and non-governmental nonprofit facilities):

The most recent FYE September 30 Medicaid nursing facility cost report serves as the base year cost report to be used for Medicaid rate setting and UPL calculations. In order to determine the Medicare allowable cost per patient day (i.e. upper payment limit), the SCDHHS:

- (1) Adjusts each nursing facility's "desk audited" allowable cost (net of cost of capital expenses) to conform to the requirements of HIM-15 (i.e. the Provider Reimbursement Manual). This is done in order to ensure that allowable costs are determined in accordance with HIM-15, as some of our Medicaid allowable cost guidelines as defined in our state plan are more restrictive than Medicare.
- (2) Desk audited cost of capital expenditures are reviewed and/or adjusted to ensure that, based upon the best information available, the capital costs reported by the provider reflect the historical costs of the prior owner in the event of a sale or lease of the nursing facility since December 15, 1981.
- (3) Total allowable costs as defined in (1) are divided by the actual number of patient days served by the provider to determine the allowable cost per patient day of the provider (net of cost of capital). This allowable cost per patient day is then increased by employing the midpoint to midpoint trending methodology using the Global Insight CMS Nursing Home without Capital Market Basket Index in order to trend the base year cost to the Medicaid rate period.

(1) Qualifications

In order to qualify for a supplemental payment as an Essential Public Safety Net nursing facility, a nursing facility must meet all of the following criteria:

- a) The nursing facility is a non-state owned governmental nursing facility in which the operator of the nursing facility is also the owner of the nursing facility assets;
- b) The nursing facility is located in the State of South Carolina;
- c) The nursing facility is licensed as a nursing facility by the State of South Carolina and is a current Medicaid provider;

(2) Upper Payment Limit Calculation

The upper payment limit effective for services beginning on and after October 1, 2011 for Essential Public Safety Net nursing facilities will be calculated using the Medicaid frequency distribution of all licensed South Carolina non-state owned governmental nursing facilities which contract with the South Carolina Medicaid Program. This frequency distribution will be determined using the Medicaid MDS assessments completed during the period which corresponds with the quarterly upper payment limit payment period (e.g. October 1 through December 31 and January 1 through March 31, etc.). The results of each nursing facility's Medicaid frequency distribution will then be applied to the total Medicaid patient days (excludes hospice room and board Medicaid patient days and coinsurance days) paid to the nursing facility during each federal fiscal year beginning October 1, 2011 in order to allocate the Medicaid days across the Medicare RUG IV categories. The applicable Medicare rates for the payment year for each RUG category will be applied against the Medicaid days for each RUG category, and then summed, to determine the maximum upper payment limit to be used in the determination of the Essential Public Safety Net nursing facility payments.

In order to adjust for program differences between the Medicare and Medicaid payment programs, the SCDHHS will calculate Medicaid payments in accordance with Section K(3)(b) of the plan.

(3) Payment Methodology

The South Carolina Department of Health and Human Services will make a supplemental Medicaid payment in addition to the standard nursing facility reimbursement to qualifying Essential Public Safety Net nursing facilities. Such payments will be made quarterly based on Medicaid patient days paid during the payment period. The payment methodology is as follows:

- a) The upper payment limit for all licensed South Carolina non-state owned governmental nursing facilities which contract with the South Carolina Medicaid Program will be computed as described under section K(1) above.

JOB TITLE	0-60 BEDS MAX ALLOWED ANNUAL SALARY	61-99 BEDS MAX ALLOWED ANNUAL SALARY	100+ BEDS MAX ALLOWED ANNUAL SALARY
DIRECTOR OF NURSING (DON)	\$63,101	\$68,729	\$83,737
RN	\$54,405	\$54,405	\$55,884
LPN	\$42,090	\$42,707	\$44,672
CNA	\$21,431	\$21,695	\$22,512
SOCIAL SERVICES DIRECTOR	\$30,392	\$35,424	\$43,590
SOCIAL SERVICES ASSISTANT	\$22,600	\$24,675	\$33,724
ACTIVITY DIRECTOR	\$25,095	\$28,096	\$31,870
ACTIVITY ASSISTANT	\$18,540	\$22,226	\$22,226
DIETARY SUPERVISOR	\$32,820	\$36,395	\$46,437
DIETARY WORKER	\$17,855	\$18,848	\$19,997
LAUNDRY SUPERVISOR	\$19,621	\$22,204	\$30,348
LAUNDRY WORKER	\$16,819	\$17,900	\$17,900
HOUSEKEEPING SUPERVISOR	\$21,873	\$24,565	\$32,532
HOUSEKEEPING WORKER	\$15,936	\$17,260	\$18,672
MAINTENANCE SUPERVISOR	\$31,341	\$35,645	\$44,120
MAINTENANCE WORKER	\$29,465	\$29,465	\$29,465
ADMINISTRATOR	\$70,075	\$85,216	\$106,360
ASSISTANT ADMINISTRATOR	\$31,782	\$51,160	\$63,741
BOOKKEEPER / BUSINESS MGR	\$33,989	\$34,408	\$41,780
SECRETARY / RECEPTIONIST	\$21,695	\$22,909	\$26,684
MEDICAL RECORDS SECRETARY	\$25,006	\$26,088	\$26,640

Note: Prior year guidelines were increased by 2.0%--the state employee pay increase effective 07/01/14

SC 15-008
EFFECTIVE DATE: 10/01/15
RO APPROVED: OCT 15 2015
SUPERSEDES: SC 13-010

G) ALLOWABLE COMPENSATION RANGES FOR OWNERS AND/OR THEIR RELATIVES EMPLOYED BY PARENT COMPANIES:

JOB TITLE	% - CEO Compensation	0-60 BEDS	61-99 BEDS	100-257 BEDS	258 + BEDS
CEO	see nh admin. Guidelines	\$ 70,075	\$ 85,216	\$ 106,360	130%* 100+ admin. Guidelines \$ 138,268
ASST CEO					
CONTROLLER					
CORPORATE SECRETARY					
CORPORATE TREASURER					
ATTORNEY	75%	\$ 52,556	\$ 63,912	\$ 79,770	\$ 103,701
ACCOUNTANT					
BUSINESS MGR					
PURCHASING AGENT					
REGIONAL ADMINISTRATOR					
REGIONAL V-P					
REGIONAL EXECUTIVE	70%	\$ 49,053	\$ 59,651	\$ 74,452	\$ 96,788
CONSULTANTS:					
SOCIAL ACTIVITY					
DIETARY (RD)					
PHYSICAL THER (RPT)					
MEDICAL RECORDS (RRA)					
NURSING (BSRN)	65%	\$ 45,549	\$ 55,390	\$ 69,134	\$ 89,874
SECRETARIES	see nh	\$ 21,695	\$ 22,909	\$ 26,684	\$ 26,684
BOOKKEEPERS	see nh	\$ 33,989	\$ 34,408	\$ 41,780	\$ 41,780
MEDICAL DIRECTOR	90%	\$ 63,068	\$ 76,694	\$ 95,724	\$ 124,441

****NOTE: there are no home offices in the 0-60 bed group**

Note: Prior year guidelines were increased by 2.0%--the state employee pay increase effective 07/01/14

- The above are maximum limits of allowable cost for owners and/or relatives who are actually performing these duties 100% of a normal work week. Part-time performance will be computed according to time spent. No individual will have more than one full time equivalent (40 hour per week) job recognized in the Medicaid program.
- No assistant operating executive will be authorized for a chain with 257 beds or less.