

PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
STATE OF SOUTH CAROLINA

The Medicaid Agency Rate Setting Policies, Procedures and Methods for Nursing Facilities, Facilities for Individuals with Intellectual Disabilities (ICF/IID), and Long Term Care Institutions for Mental Diseases

I. Cost Finding and Uniform Cost Reports

- A) Each nursing facility shall complete and file with the Medicaid Agency, Division of Long Term Care Reimbursements, an annual financial and statistical report supplied by the Medicaid Agency. Effective for the cost reporting period ending September 30, 2001, all nursing facilities will be required to submit their financial and statistical report using the new SENIORS (South Carolina Electronic Nursing Home Income/Expense Operating Report System) program software provided by the Medicaid Agency. Nursing facilities must report their operations from October 1 through September 30 on a fiscal year basis. Government owned and ICF/IID facilities may report their operations from July 1 through June 30. Hospital based facilities with fiscal year ends other than September 30 will be allowed effective with the 1990 cost reports to use their fiscal year end due to the reporting difficulties of nonconcurrent Medicare and Medicaid fiscal year ends. However, no additional inflation adjustment will be made.

Effective October 1, 2010, nursing facilities which have an annual Medicaid utilization of 3,000 days or less will not be required to file an annual financial and statistical report.

Nursing facilities which incur home office cost/management fees through a related organization are responsible for submitting a hard copy of an annual cost report detailing the cost of the related organization (home office) to the Medicaid Agency. The cost report period should be from October 1 to September 30. However, large chain operations which do business in other states may request a different cost reporting period for their home office cost report; however, no additional inflation adjustment will be made.

- B) Nursing facilities are required to detail their cost for the entire reporting period or for period of participation in the plan, if less than the full cost reporting period. These costs are recorded by the facility on the basis of generally accepted accounting principles and the accrual method of accounting. The cash method of accounting is acceptable for public institutions.

- C) Nursing facilities are required to list the cost of the various services provided under the plan in accordance with the Medicaid Agency's cost reporting format. However, facilities providing services not covered by the plan will be required to use a step down method of cost finding as described in 42 CFR 413.24(d)(1) to apportion cost between the services covered and the services not covered by the plan before listing the cost of the various services provided under the plan. Services not covered by the plan include, but are not limited to, private pay wings of a facility which participates in the Medicaid (XIX) Program. In regard to stepping down capital related cost and maintenance cost of a private pay wing, the facility must allocate capital related cost (depreciation, interest, etc.) and maintenance cost directly associated with the wing in lieu of using square footage as the statistical base for allocating total capital costs and maintenance costs of the facility.
- D) Nursing facilities are required to report cost on a Uniform Cost Report form provided by the Medicaid Agency. All Uniform Cost Reports must be filed with the Medicaid Agency no later than January 1. However, a thirty (30) day extension of the due date may be granted for good cause. Effective for the cost reporting period ending September 30, 2001, nursing facilities will be required to submit their financial and statistical report using the SENIORS software program. Hospital based/related nursing facility cost reports will be due no later than 30 calendar days after the due date of the hospital's Medicare cost report.

The financial and statistical report shall be certified by the operator of a proprietary medical facility, an officer of a voluntary medical facility, or the public official responsible for the operation of a public medical facility.

A new contract will not be executed until all cost reporting requirements are satisfied. Additionally, if such report properly executed has not been submitted by the required date, the Medicaid Agency shall withhold all funds, or any portion thereof to be determined by the Director, due the Provider until such report is properly submitted and a new contract executed.

E) All nursing facilities are required to retain all financial and statistical records for each cost reporting period, which are accurate and in sufficient detail to substantiate the cost data reported for a period of at least four (4) years following the end of the contract period for which the cost report was used to set this rate. These records must be made available upon demand to representatives of the Medicaid Agency, or the State Auditor, or the Centers for Medicare and Medicaid Services. The Medicaid Agency will retain all cost reports for four (4) years after the end of the contract period for which the cost report is used to set the rate. If any litigation, claim, negotiation, or other action involving the records has been started before the expiration of the four (4) year period, the records shall be retained until completion of the action and resolution of all issues which arise from it, or until the end of the regular four (4) year period, whichever is later.

F) Allowable costs shall include all items of expense which Providers must incur in order to meet the definition of nursing facility services as detailed in 42 CFR 440.40 and or 440.150 as promulgated under Title XIX of the Social Security Act, and in order to comply with standards for nursing facility care in 42 CFR 442 and in order to comply with requirements of the State Agency for establishing and maintaining health standards under the authority of 42 CFR 431.610 and in order to comply with any other requirements for nursing facility licensing under the State law.

- 1) Allowable costs are determined in accordance with Title XIX of the Social Security Act, 42 CFR USCA 1396, et seq. and Federal Regulations adopted pursuant to the Act; the Medicaid Agency regulations; Title XVIII of the Social Security Act, 42 CFR USCA 1395 et seq., Federal regulations adopted pursuant thereto and HIM-15, except those provisions which implement Medicare, retrospective, as opposed to Medicaid's prospective, reimbursement system or those provisions which concern the relationship between the provider and Medicare intermediary or are modified by this Plan.
- 2) Bad debts, charity and courtesy allowance shall not be included in allowable costs except that bad debts that are attributed to cost sharing amounts as defined in 42 CFR 447.50 and 447.59 shall be allowable.
- 3) Allowable cost shall be categorized as follows: (The application is defined in Section III, Payment Determination).

a) Cost Subject to Standards:

- i) General Services: Nursing, Social Worker, and Activity Director and related cost.
- ii) Dietary
- iii) Laundry, Maintenance, and Housekeeping
- iv) Administration and Medical Records & Services

b) Cost Not Subject to Standards:

- i) Utilities
- ii) Special Services
- iii) Medical Supplies and Oxygen
- iv) Property Taxes and Insurance - Building and Equipment
- v) Legal Fees

- c) Cost of Capital: The cost of capital reimbursement plan effective July 1, 1989 replaces the prior cost of capital and return on equity policy with one that reimburses costs on the basis of market returns for the current reasonable value of the assets. The plan reduces the wide disparity in the cost of capital payments for basically the same service and makes the cost of capital payment fairer to all participants in the program. The plan also bases reimbursement on investments in facilities of reasonable quality, and does not provide incentives for investment in unnecessarily expensive facilities.

The first step of the plan estimates a reasonable fair market rental value for nursing home beds and assigns each facility a "Deemed Asset Value" based on its number of beds and the fair market rental value of a bed. Secondly, each facility is assigned a "Deemed Depreciated Value" for its assets equal to its Deemed Asset Value less actual accumulated depreciation that the provider has reported in accordance with Medicare/Medicaid guidelines. The next step is to determine a market rate of return that will provide the incentives required to keep the industry reimbursement for the cost of capital will be the return on the Deemed Depreciated Value, expressed in terms of patient days.

This cost of capital methodology replaces the prior reimbursement for interest and return on equity. Reimbursement rates for leased facilities are limited to a factor based on the return for the Deemed Depreciated Value of the leased facilities and costs associated with facility leases will not be reimbursed separately. Lease costs associated with equipment rentals (separate from a facility lease) will be reflected in the affected cost centers. Effective October 1, 1993 non-related party home office building rent expense will be classified in the administrative cost center. Depreciation expense applicable to related party home office rental transactions will continue to be classified under cost of capital. The State will continue to provide a reimbursement for actual depreciation based on the original cost of the asset for those facilities put into operation prior to July 1, 1989. A facility's accumulated depreciation will be grandfathered in for that facility in the event of a sale or lease to a new operator. The Deemed Asset Value will be adjusted each year for inflation. The maximum increase that will be allowed will be reflected in the index of home owner's rental value, based on increases in the index of home owner's rental value over the latest three calendar years, as computed by the Division of Research and Statistics of the Budget and Control Board, based on the latest data published by the Bureau of Labor Statistics. However, a lesser amount of inflation may be granted by the Medicaid agency due to compliance with the Medicare upper limits test. 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).

1) Calculation of Base Period Asset Cost

To avoid the problem of market distortions, this plan selects the average of original costs for facilities established during 1980 and 1981 as the "Original Asset Cost" for determining the fair market rental value for a comparable service during federal cost year 1987-1988. Asset values are those reported by the operators on their original filings. Those two years were the latest prior to the freeze on the value of resales and the limit on interest and depreciation reimbursements. Two years, instead of one, were selected in order to broaden the size of the sample, and to obtain a fairer estimate of the base costs.

**SC: MA 99-012**  
**EFFECTIVE DATE: 10/01/99**  
**RO APPROVED: 03/10/00**  
**SUPERSEDES: MA 97-008**

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 2015-2016, this index rose 253.669 percent.

Inflating the base period market value of \$15,618 by the index for homeowner's rent, the "Deemed Asset Value" for cost year 2015-2016 is \$55,236 per bed and will be used in the determination of nursing facility rates beginning October 1, 2017.

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

participation will determine the allowable percentage of Medicaid depreciation and amortization costs to be used in determining total allowable Medicaid costs for any new beds coming on line on or after July 1, 1989. Effective for services provided on or after October 1, 2016, the Medicaid Agency will no longer establish a separate bed class for a minor bed addition that results from the conversion of private rooms into semi private rooms for cost of capital reimbursement purposes. In this scenario, the additional beds will be reflected within the bed group class where the beds were added and the capitalized costs associated with the addition of the beds will be reflected within this bed group. The only exception to this criteria will be when the additional beds result in the creation of a new wing. Under this scenario, a new bed group class will be created for cost of capital reimbursement purposes. In order to receive Medicaid reimbursement for these beds under either scenario, the beds must be certified for Medicaid participation. Furthermore, that portion of the cost of capital reimbursement applicable to these new beds will not be subject to the \$3.00 cap.

In order to determine cost of capital reimbursement for these facilities, two cost of capital computations will be completed (for existing and new beds). To determine an equitable capital reimbursement, a formula determination for the new beds utilizing annualized data will be computed and then weighted with the values calculated for the existing beds. The weights will be projected utilization of existing and new beds during the rate cycle, with minimum occupancy being 90%.

The actual cost of any additions to new beds after July 1, 1989 will be added to the Deemed Asset Value for the purpose of computing depreciation charges. For clarification purposes, any capital expenditures incurred after the certification date of the new beds during the initial cost report period will not be considered as improvements, but as part of actual construction costs.

For facilities where there are no historical costs available, the plan computes a Deemed Depreciated Value based on the Base Period Asset Cost, adjusted to the year of construction using the index for home owner's rent, spread over a depreciation period applicable to the year of construction under Medicare guidelines.

The allocation of the base 1981 nursing home bed cost (\$15,618) by component is as follows:

<u>Asset Component</u>	<u>Cost Per Bed</u>	<u>Percentage of Total</u>
Land	\$ 461	2.95%
Building	12,274	78.59%
Equipment and Other	2,883	18.46%
Total	<u>\$15,618</u>	<u>100.00%</u>

A useful life of 40 years will be assigned to the building and a composite useful life of 12 years will be assigned to the equipment and other.

4) Determination of the Market Rate of Return

The plan provides the lowest rate of return to investors that would provide incentives to keep the industry expanding sufficiently to meet the growing needs of Medicaid patients. The industry may need approximately three to four million dollars per year of new investments to keep up with the growing population and the demand for Medicaid services in the near future.

In determining that rate of return, the question is, "where can that money be raised and what rate of return will be necessary to raise

SC 16-0006

EFFECTIVE DATE: 10-01-16

RO APPROVED: 09/30/16

SUPERSEDES: SC 12-013



that kind of money." Part of the funds could be raised by borrowing from the banks. But this would be rather costly for the small investor, who would probably have to pay a rate of interest in excess of the prime rate.

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 State of South Carolina Revenue and Fiscal Affairs Office, based on latest data published by the Federal Reserve. Effective October 1, 2017, this rate is 2.92%.

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

average facility of 100 beds, based upon federal cost year 1987-1988, which is used for computing state fiscal year rates effective July 1, 1989. In this illustration, the average accumulated depreciation for the industry is used to compute an average Deemed Depreciated Value. Under the plan, each operator will use the accumulated depreciation applicable to his own facility to calculate the Deemed Depreciated Value of his facility. Beginning in federal cost year 1987-1988, which was used for computing state fiscal year 1989-1990 rates, the Deemed Asset Value was set at \$23,271 for each bed.

The Deemed Asset Value of the facility would be the fixed \$23,271 per bed multiplied by the number of beds, which would amount to \$2,327,100 for the average 100 bed facility. To determine the amount of Deemed Depreciated Value for an individual facility, the amount of depreciation costs the provider has reported in accordance with Medicare/Medicaid guidelines would be subtracted from the Deemed Asset Value of the facility and the value of improvements added to the Deemed Asset Value. The average amount of accumulated depreciation for a 100 bed facility is \$356,827.

The estimated Deemed Asset Value of the facility less the accumulated depreciation would yield an average Deemed Depreciated Value of \$1,970,273 for this average facility. In this example, improvements were assumed to be zero, but an operator would add on the value of any improvements.

At the July 1, 1989 market rate of return of 9.8 percent the annual return would be \$193,087. At July 1, 1989, the total capacity of 36,500 patient days for the facility less the two percent turnover factor, would yield a facility capacity factor of 35,770 patient days. Actual patient days will be used if actual occupancy exceeds 98 percent. Effective October 1, 1995, minimum occupancy is established at 97%. Effective October 1, 2000, the minimum occupancy is established at 96%. Effective October 1, 2012, the minimum occupancy is established at 92%. Effective October 1, 2016, the minimum occupancy is established at 90%. This would yield a payment by the State of \$5.40 per patient day for each day of Medicaid service. The annual return for the facility will replace facility lease costs and capital interest costs (excluding specialty vehicle interest which is directly charged to the appropriate cost center) reflected under the cost of capital cost center. Lease costs associated with equipment rentals (separate from a facility lease) will be reflected in the affected cost centers.

Table 1

METHOD FOR CALCULATING COST OF CAPITAL REIMBURSEMENT  
EFFECTIVE JULY 1, 1989

Original Asset Cost 1980/1981	\$	15,618
<u>Inflation Adjustment to Cost Year 1987-1988</u>	X	1.49
Deemed Asset Value FY 87-88	\$	23,271
<u>Number of Beds</u>	X	100
Deemed Asset Value of Facility		2,327,100
Improvements Since 1981		0
<u>Accumulated Depreciation</u>		(356,827)
Deemed Depreciated Value		1,970,273
<u>Market Rate of Return</u>	X	9.8%
Annual Return for Facility		193,087
<u>Facility @ 98% Capacity*</u>		35,770
Return per Bed per Patient Day	\$	5.40

\*Effective October 1, 1995, minimum occupancy is established at 97%.

\*Effective October 1, 2000, minimum occupancy is established at 96%.

\*Effective October 1, 2012, minimum occupancy is established at 92%.

\*Effective October 1, 2016, minimum occupancy is established at 90%.

7) Income Offsets

Income offset adjustments as defined in HIM-15, section 202.2 will continue to be made, except that income adjustments will be limited to the amount of the annual return per facility (see Table 1), plus working capital and specialty vehicle interest, in lieu of actual interest expense.

8) Limit on Cost of Capital Reimbursement

Cost of capital reimbursement effective July 1, 1989 cannot exceed the audited cost of capital and return on equity per diem payment reimbursed prior to July 1, 1989 (i.e., cost of capital and return on equity per diem payment on June 30, 1989) by more than \$3.00 per patient day. The \$3.00 cap is applicable only to those beds that were being reimbursed on June 30, 1989. Any new beds coming on line on or after the cost reporting period used to set the June 30, 1989 Medicaid payment rate will not be subject to the \$3.00 cap. In order for nursing facilities to recognize the increase in the Deemed Asset Value in future years, the \$3.00 limit on the capital per diem payment will be inflated each year by the index for the rental value of a home computed as part of the CPI (i.e., the same index used to determine the Deemed Asset Value each year). This rate (rental value index) will be supplied by the Budget and Control Board's Division of Research and Statistical Services each year. The cap effective October 1, 1995, inflated by 4.2% is \$3.99. Effective October 1, 1996, the cap will be frozen at \$3.99. Effective October 1, 2016, the cap is \$5.00.

State operated facilities will continue to be reimbursed their actual capital costs (depreciation, interest, lease, and amortization costs).

d) Lease and Sales

The South Carolina Department of Health and Human Services will treat any new lease or sale of a facility executed after December 15, 1981, as a related party transaction. Therefore, in the event of a sale after December 15, 1981, the provider's capital related cost will be limited to the lower of the sales price or the historical cost of the prior owner. In the event of a lease executed after December 15, 1981, the provider's capital related cost will be limited to the lower of the lease cost or the historical cost of the owner (lessor). The historical costs of the prior owner would include:

- a) Depreciation expense of the prior owner.
- b) Interest expense which will be limited to the prior owner's expense.
- c) Prior owner's equity in the facility.

However, in the event of a sale or lease on and after July 1, 1989, the provider's (new owner) capital related cost will be limited to the cost of capital reimbursement received by the prior owner (i.e., cost of capital payment for the new owner will be the same as the old owner). No revaluation of assets will be recognized by the South Carolina Medicaid Program as a result of a sale.

No recapture of depreciation will be necessary from the prior owner unless the prior owner used accelerated depreciation in excess of the allowable straight line depreciation, or depreciation was overstated over the allowable straight line depreciation because of the application of a shorter useful life in calculating the depreciation.

II. Auditing

- A) All cost reports will be desk reviewed by the Medicaid Agency. The Provider will be notified of the desk review exceptions and the provider has the right to respond within fifteen (15) days.
- B) All cost reports are subject to on-site audit. Any overpayments determined as a result of on-site audits will be collected after issuing the final audit report and accounted for on the CMS-64 report no later than the second quarter following the quarter in which the final audit report is issued. The provider has the right to appeal the final audit decision through the appeal process. The appeal decision will be binding upon the SCDHHS.

III. Payment Determination

The rate cycle will be October 1 through September 30 and will be recomputed every twelve (12) months, utilizing the cost reports submitted in accordance with Section I, Cost Finding and Uniform Cost Reports, of the Plan.

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. 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 90% are currently being utilized for Medicaid rate setting purposes. For clarification purposes, nursing facility beds that are taken off-line due to renovation/construction issues relating to unsafe building conditions and considered unusable to meet the SC Department of Health and Environmental Control survey and certification guidelines will be temporarily excluded from the minimum occupancy computation for Medicaid rate setting purposes. Effective on and after October 1, 2013, Medicaid rates for nursing facilities located in counties where the county occupancy rate is less than 85% based upon the FYE September 30 cost report information will be established using the following policy:

- The SCDHHS will waive the 90% minimum occupancy requirement used for rate setting purposes for those nursing facilities located in counties whose occupancy is less than 85%. However, standards will remain at the 90% 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. However, the SCDHHS will not participate in establishing payment rates using an occupancy rate of less than eighty-five percent (85%).

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

SC 18-0001  
EFFECTIVE DATE: 01/01/18  
RO APPROVED: 06/11/18  
SUPERSEDES: SC 17-0006

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. General Services cost center standards will be computed using private and non-state owned governmental free standing and hospital based nursing facilities. All other cost center standards will be computed using private for profit free standing nursing facilities. 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 (366 x 90%).
- 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. Total patient days are determined by taking maximum bed days available from each bed group, subtracting complex care days associated with each bed group, and multiplying the net amount by 90%.
  - 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 90% occupancy, actual days will be adjusted to reflect 90% 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 Revenue and Fiscal Affairs Office 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 2016 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 2016.
  - 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 2017 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 2017.
  - c. The percent change in the total proxy index during the third quarter of 2016 (as calculated in step a), to the total proxy index in the third quarter of 2017 (as calculated in step b), was 2.90%. Effective October 1, 2017 the inflation factor used was 2.90%.
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 90% occupancy, actual days will be adjusted to reflect 90% 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.

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

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 percent (90%) 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<sup>st</sup>) day of the seventh (7<sup>th</sup>) 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.
- d) The Medicaid agency will determine the percent of Level A Medicaid patients serviced for a facility that changes its bed capacity by more than fifty percent (50%) using the most recent twelve months of data (See Page 15, Paragraph B-1 (e) for the time periods) as reflected on the SCDHHS Medstat report to establish rates.
- e) The Medicaid agency will determine the percent of Level A Medicaid patients served for a new facility based upon paid days during the last month of the initial cost report period as reflected on the SCDHHS Medstat report to establish rates.

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.

This report will be used to determine allowable reimbursement of the provider for the initial rate cycle. 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. No inflation adjustment will be made to the interim rates for the first six (6) months cost. Payment for the first six months will be retrospectively adjusted to actual costs not to exceed the standards. Effective on the first (1<sup>st</sup>) day of the seventh (7<sup>th</sup>) month of operation, 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.

The Medicaid agency will determine the percent of Level A Medicaid patients served for a replacement facility or a change of ownership, using the most recent twelve months of data (See Page 15, Paragraph B-1 (e) for the time periods) as reflected on the SCDHHS Medstat report to establish rates.

3. Payment determination for a change in ownership through a purchase of fixed assets or lease of fixed assets:

A change in ownership will be defined as a transaction (i.e. a sale or lease of fixed assets) that results in a new operating entity and occurs between unrelated parties. A purchase of the leased fixed assets by a lessee (owner of operating entity) will not be considered a change of ownership unless allowable Medicaid capital costs will be reduced (i.e., purchase price less than historical costs). Each change of ownership request will be reviewed individually. Nursing facilities in the process of obtaining a certificate of need due to a sale or lease between unrelated parties prior to October 1, 2014 will be grandfathered in under the prior system.

Purchase of Fixed Assets

For a change in ownership due to a purchase of fixed assets, the new owner will receive the prior owner's most recent Medicaid rate upon the effective date of the change in ownership (purchase) and subsequent Medicaid reimbursement rates will be based upon the most recently filed fiscal year end September 30 cost report of the prior owner adjusted for any industry wide inflation trend or industry wide add-on until the new owner files a minimum nine month cost report which ends September 30. For clarification purposes, the new owner's rate will not be subject to the effect of any audits performed on the prior owners rate.

Lease of Fixed Assets

For a change in ownership due to a lease of fixed assets, the new owner will receive the prior owner's most recent Medicaid rate upon the effective date of the change in ownership (lease) and subsequent Medicaid reimbursement rates will be based upon the most recently filed fiscal year end September 30 cost report of the prior owner adjusted for any industry wide inflation trend or industry wide add-on until the new owner files a minimum nine month cost report which ends September 30. For clarification purposes, the new owner's rate will not be subject to the effect of any audits performed on the prior owners rate.

4. Rate determination for a facility in which temporary management is assigned by the state agency to run the facility:

In the event of the Medicaid agency having to place temporary management in a nursing facility to correct survey/certification deficiencies, reimbursement during the time in which the temporary management operates the facility will be based on 100% of total allowable costs subject to the allowable cost definitions set forth in this plan, effective October 1, 1990. These costs will not be subject to any of the cost standards as reflected on page 4 of the plan. Capital reimbursement will be based on historical cost of capital reimbursement in lieu of the Medicaid agency's current modified fair rental value system. Initial reimbursement will be based on projected costs, with an interim settlement being determined once temporary management files an actual cost report covering the dates of operation in which the facility was being run by the temporary management.

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.



To determine the July 1, 2017 baseline ICF/IID per diem rate, the total allowable Medicaid reimbursable costs of each ICF/IID 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 year Medicaid per diem cost to the payment period, the agency will employ the use of the midpoint to midpoint methodology and the use of the third quarter 2016 Global Insight Indexes - 2010 Based CMS Skilled Nursing Home Market Basket Index.

In addition to the July 1, 2017 baseline per diem rate calculation reflected above, the Medicaid Agency will provide for an add-on to each ICF/IID rate to account for the legislatively imposed direct care worker wage increase as mandated by the South Carolina General Assembly during the July 1, 2017 through June 30, 2018 state appropriations process. The add-on rate will be determined based upon a \$.89 increase in the hourly wage rate as well as the application of a twenty-one percent (21%) fringe benefit factor which takes into account the employer's share of FICA (7.65%) and the SC Retirement System contribution (13.56%). Full time direct care worker equivalents (FTEs) will be derived from SFY 2017 payroll surveys and will be increased by ten percent (10%) to take into account vacancy factors and anticipated overtime costs. The annual number of hours worked by each FTE will equal 2,080 hours. The July 1, 2017 direct care worker wage increase cost will then be divided by state fiscal year 2017 total patient days to determine the July 1, 2017 direct care worker wage increase add-on amount.

In order to determine the statewide per diem ICF/IID rates (institutional rate or community rate) effective July 1, 2017, the Medicaid Agency will employ the following process:

- (1) First, the ICF/IIDs are separated by class (institutional or community). The July 1, 2017 baseline rate of each ICF/IID within each class is multiplied by the number of incurred SFY 2016 Medicaid patient days obtained via MMIS to determine the annual projected Medicaid cost of each ICF/IID for Medicaid rate setting purposes.
- (2) Next, in order to determine a weighted average statewide baseline rate for each class of ICF/IID facility (community and institutional), the aggregate Medicaid cost as determined in step (1) for each class is divided by the sum of the incurred SFY 2016 Medicaid patient days for each class to determine the statewide weighted average for each class.
- (3) Finally, the weighted average statewide baseline rate as determined in step (2) for community and institutional ICF/IID's is increased by the amount of the weighted average statewide direct care worker add-on determined for each class of ICF/IID (community and institutional) to determine the rates effective July 1, 2017.

Medicaid payment to the ICF/IID includes, but is not limited to, reimbursement for the following services:

- a) Room and board including all of the items necessary to furnish the individual's room (luxury items/fixtures will not be recognized as an allowable cost). 42 CFR §483.470(b), (c), (d), (e), (f), and (g) (1).
- b) Direct care and nursing services as defined for each living unit of the facility. 42 CFR §483.460(c).
- c) Training and assistance as required for the activities of daily living, including, but not limited to, toileting, bathing, personal hygiene and eating as appropriate. 42 CFR §483.440(a).
- d) Walkers, wheelchairs, dental services, eyeglasses, hearing aids and other prosthetic or adaptive equipment as needed. If any of these services are reimbursable under a separate Medicaid program, the cost will be disallowed in the cost report (effective for cost reporting periods beginning July 1, 1989).
- e) Maintenance in good repair of dentures, eyeglasses, hearing aids, braces, and other aids prescribed for a resident by an appropriate specialist effective for cost reporting periods beginning July 1, 1989. 42 CFR §483.470(g) (2).
- f) Therapy services including, but not limited to, speech, recreation, physical, and occupational, as prescribed by the resident's individual habilitation plan. 42 CFR §483.430(b).
- g) Transportation services as required to provide other services including vehicles with lifts or adaptive equipment, as needed. The cost of ambulance services will not be included as part of allowable costs.
- h) Psychological services as described in 42 CFR §483.430(b) (1) and (b) (5) (v).
- i) Recreational services as described in 42 CFR §483.430(b) (1) and (b) (5) (viii).
- j) Social services as described in 42 CFR §483.430(b) (1) and (b) (5) (vi).

- 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/IID 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. See Section Q which describes the certified public expenditure review process and retrospective cost settlement process for state owned/operated ICF/IIDs. 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.

#### I. Complex Care Reimbursement Program

Effective for services provided on or after October 1, 2011, the South Carolina Department of Health and Human Services will implement its Complex Care Program. The Complex Care Program is a patient assessment driven system that will provide financial incentives to nursing facilities who admit Medicaid beneficiaries with complex care needs. Medicaid beneficiaries who qualify for the Complex Care Program must meet the South Carolina Level of Care Criteria (Skilled or Intermediate) for Long Term Care and have multiple

needs which fall within the higher ranges of disabilities in the criteria. To qualify as a Medicaid complex care beneficiary, the individual must meet the level of care for long-term care plus two or more of the following criteria:

- Wound/decubitus care - Stage 4 requiring wound vac treatment
- Tracheostomy Tube/Canula - sinus alone does not qualify, must have the following: tube/canula, need for aseptic care, need for tracheal aspiration
- Nasopharyngeal or suctioning - oral and pharyngeal aspiration does not apply
- Continuous parental fluids of extended duration of two weeks or more
- Continuous disruptive behavior at least 60% of the time in a 24/hr. day, 7 days a week resulting often from head trauma accidents, neuro deficits, bi-polar affective disorder and/or other chronic mental illnesses
- Diagnosis of HIV - usually related to drug costs and IV medications
- Morbid obesity/bariatric requiring special equipment such as beds, lifts, additional staff
- Medicaid only beneficiary who require goal directed therapies (occupational therapy, speech therapy, physical therapy) that addresses a recently diagnosed medical condition, within the last six (6) months
- Dialysis
- Total care as defined by the skilled long term care criteria

The Complex Care Program reimbursement rate effective October 1, 2011 will be \$450.00 per patient day and was developed based upon an analysis of the Medicaid RUG scores developed from federal fiscal year 2011 Medicaid MDS assessments and federal fiscal year 2011 Medicare RUG rates. The complex care rate will be used to reimburse nursing facilities for their base operational costs as well as the additional costs incurred in providing services to the qualifying individuals such as:

1. Staff time (both by skilled professional and nurse aides) to perform actual procedures or provide additional care;
2. Necessary supplies, specialized equipment such as lifts, special beds, etc. needed to provide the care, and/or nutritional supplements; and
3. Staff education required to be able to provide for the beneficiary with complex care needs.

Nursing facilities that provide services to complex care individuals meeting the criteria defined above will be required to step down cost applicable to this service in accordance with Section I (C) of this plan upon submission of their annual cost report.

Ventilator Unit Reimbursement Program

Effective for services provided on or after October 1, 2017, the South Carolina Department of Health and Human Services will update its per diem payment for services provided to ventilator dependent Medicaid beneficiaries residing in a ventilator dependent wing of a contracting South Carolina Medicaid nursing facility. To qualify for this reimbursement, the wing must consist of a minimum of 20 nursing facility beds that are dedicated solely to the provision of ventilator dependent services. Effective for services provided on and after October 1, 2017, the vent rate will equal \$530.00 per Medicaid patient day. This rate was determined based upon the Medicaid Agency's review of proposed Medicare FFY 2018 RUG rates associated with the provision of ventilator dependent services.

The ventilator unit rate will be used to reimburse nursing facilities for their base operational costs as well as the individual costs incurred in providing services to these individuals such as:

1. Staff time (both by skilled professional and nurse aides) to perform actual procedures or provide additional care;
2. Necessary supplies, specialized equipment such as lifts, special beds ventilators, etc. needed to provide the care, and/or nutritional supplements; and
3. Staff education required to be able to provide for the beneficiary with vent needs.

Nursing facilities that provide services to Ventilator Unit individuals will be required to step down cost applicable to this service in accordance with Section I (C) of Attachment 4.19-D upon submission of their annual cost report.

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.
- (4) Total allowable cost of capital expenditures as defined in (2) are divided by the actual number of patient days served by the provider to determine the allowable cost of capital expense per patient day of the provider. No inflation trend is applied to the cost of capital per diem.
- (5) The cost per diem as determined in (3) and (4) above are added together to determine the Medicaid rate per day based upon Medicare allowable cost definitions (i.e. HIM-15).
- (6) Medicaid days paid (excluding NF days paid for recipients while under the Hospice Benefit) based upon the most recently completed state fiscal year are applied to the Medicaid cost based rate as defined in (5) above and the Medicaid rate as calculated in accordance with the state plan methodology to determine the annual Medicaid payments for each provider under each rate method described above.

- (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.

- (2) To estimate the calculated Medicare upper payment limit for the September quarter, the payments for the three preceding quarters are summed and divided by three for each nursing facility. The estimated Medicaid paid days for the September quarter are also determined using the same methodology.
- (3) The calculated quarterly Medicare upper payment limits identified in (1) above are added to the estimated September quarter Medicare upper payment limit as identified in step (2) to determine the annual estimated Medicare upper payment limit for the preceding federal fiscal year for each nursing facility. Annual estimated Medicaid paid days for the preceding federal fiscal year are also determined using the same methodology.
- (4) In order to estimate the annual Medicare upper payment limit for the upcoming federal fiscal year which begins October 1<sup>st</sup>, the annual estimated Medicare upper payment limit of the preceding federal fiscal year as determined in step (3) above is multiplied by the applicable Medicare SNF PPS Market Basket Rate (net of the Productivity Adjustment) applicable to the next federal fiscal year.
- (5) In order to estimate the annual Medicaid rate payments for each nursing facility for the next federal fiscal year, the Medicaid adjusted per diem rate applicable to the next federal fiscal year (which includes the base Medicaid per diem rate, the Medicaid per patient day pharmacy cost, and the Medicaid per diem lab, x-ray, and ambulance cost) is multiplied by the estimated Medicaid paid days as determined in step (3) above.
- (6) The Medicaid UPL compliance check is determined for the non-state owned governmental nursing facility class by comparing the aggregate amounts as determined in (4) above to ensure that the projected Medicare upper payment limit is equal to or greater than projected Medicaid nursing facility expenditures determined in step (5).

III. Essential Public Safety Net Nursing Facility Supplemental Payment

As directed by the actions of the South Carolina General Assembly via proviso Number 21.39 of the State Fiscal Year 2008/2009 State Appropriations Act, the South Carolina Medicaid Program will implement an Upper Payment Limit Payment Program for qualifying non-state owned governmental nursing facilities.

Therefore, for nursing facility services reimbursed on or after October 1, 2011, qualifying Medicaid nursing facilities shall receive a Medicaid supplemental payment (in addition to the per diem payment). The qualification, upper payment limit calculation, and payment methodology are described below.



(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.

**SC 15-008**  
**EFFECTIVE DATE: 10/01/15**  
**RO APPROVED: 10/10/15**  
**SUPERSEDES: SC 11-021**

- b) Medicaid reimbursement payments for all licensed South Carolina non-state owned governmental nursing facilities which contract with the South Carolina Medicaid Program will be computed using the corresponding federal fiscal year Medicaid days paid during the period beginning October 1, 2011. The Medicaid reimbursement payments will incorporate: (1) the gross per diem payments based upon the Medicaid rate(s) in effect during the payment period as computed in accordance with the state plan, and (2) ancillary service payments which are not reflected within the gross Medicaid rate. The ancillary services would include pharmacy, lab, x-ray and ambulance. In order to determine these costs, only Medicaid eligible recipients residing in nursing facilities will be used. Additionally, Publications 12 (The Skilled Nursing Facility Manual) and 100-04 (Medicare Claims Processing Manual) will provide the criteria to be used in determining the appropriate pharmacy, lab, x-ray and ambulance services to be pulled. Eligibility information from MEDS as well as paid claims data from MMIS and/or Medstat will be used in the analysis. In order to adjust the ancillary service costs to a per patient day basis, the number of nursing facility days paid on behalf of each individual will also be accumulated from MMIS and/or Medstat.
- c) The sum of the upper payment limit as described in K(3) (a) will be reduced by the sum of the Medicaid reimbursement payments as described in K(3) (b) to determine the amount of the upper payment limit payments to be paid to each Essential Public Safety Net nursing facilities (as defined in section K(1)).

The total payments made to the licensed South Carolina non-state owned governmental nursing facilities that contract with the South Carolina Medicaid Program, including the Essential Public Safety Net nursing facility supplemental payments, will not exceed the aggregate Upper Payment Limit amount for the non-state owned governmental nursing facilities. Additionally, the Essential Public Safety Net nursing facility supplemental payments will not be subject to the lower of costs or charges limitation.

#### IV. State Owned Governmental ICF/IID Service Providers

The following methodology is used to estimate the upper payment limit applicable to state owned governmental Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) facilities:

The SFY 2010 2552 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 using Medicare allowable cost principles (i.e. upper payment limit), the SCDHHS employs the following process:

- (1) First, allowable Medicaid reimbursable cost for each ICF/IID is obtained from worksheet B Part I, Column 21 of the Medicaid Regional ICF/IID cost report. The Medicaid allowable reimbursable cost of each ICF/IID is then divided by total patient days incurred by each ICF/IID to determine the base year per diem cost of each ICF/IID. Total patient days are derived from the

individual worksheet summaries provided within each  
Medicaid Regional ICF/IID cost report.

- (2) The Medicaid ICF/IID per diem cost as determined in step (1) for each facility is then trended by the compounding of three years of the Skilled Nursing Facility Market Basket Index rates (prior to productivity adjustment) utilized by Medicare in order to trend the base year per diem cost to the Medicaid rate period. This would include the use of the FY 2011, 2012 and 2013 Market Basket rates. To determine trended Medicaid ICF/IID cost for each ICF/IID for the October 1, 2012 through September 30, 2013 demonstration period, their individual trended per diem cost rate is multiplied by the base year Medicaid incurred patient days which is obtained via MMIS.
- (3) Total annual projected Medicaid ICF/IID revenue of each facility for the October 1, 2012 through September 30, 2013 payment period is derived by taking the October 1, 2012 Medicaid rates of each ICF/IID facility and multiplying this rate by the facility's SFY 2010 incurred Medicaid days.
- (4) The Medicaid UPL compliance check is determined for this class by comparing the aggregate amounts as determined in step (2) above to ensure that projected Medicaid ICF/IID cost is equal to or greater than projected Medicaid ICF/IID rate expenditures in step (3). In the event that aggregate Medicaid ICF/IID rate expenditures exceed aggregate Medicaid ICF/IID cost, the Medicaid ICF/IID rate for each facility will be limited to the Medicaid cost based rate as determined in (2) above.

V. State Owned Governmental Nursing Facility Service Providers

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

The SFY 2010 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 using Medicare allowable cost principles (i.e. upper payment limit), the SCDHHS employs the following process:

- (1) First, allowable Medicaid reimbursable cost for each nursing facility is obtained from the adjusted column of The Revenue and Expense Summary worksheet of the Medicaid nursing facility cost report, less any applicable desk audit adjustments. The Medicaid allowable reimbursable cost of each nursing facility is then divided by total patient days incurred by each nursing facility to determine the base year per diem cost. Total patient days are derived from the Census worksheet contained within the Medicaid nursing facility cost report.

- (2) The Medicaid nursing facility per diem cost as determined in step (1) for each facility is then trended by the compounding of three years of the Skilled Nursing Facility Market Basket Index rates (prior to productivity adjustment) utilized by Medicare in order to trend the base year per diem cost to the Medicaid rate period. This would include the use of the FY 2011, 2012 and 2013 Market Basket rates. To determine trended Medicaid nursing facility cost for each facility for the October 1, 2012 through September 30, 2013 demonstration period, the individual trended per diem cost rate is multiplied by the base year Medicaid incurred patient days which is obtained via MMIS.
- (3) Total annual projected Medicaid nursing facility revenue of each facility for the October 1, 2012 through September 30, 2013 payment period is derived by taking the October 1, 2012 Medicaid rates of each nursing facility and multiplying this rate by the facility's SFY 2010 incurred Medicaid days.
- (4) The Medicaid UPL compliance check is determined for this class by comparing the aggregate amounts as determined in step (2) above to ensure that projected Medicaid nursing facility cost is equal to or greater than projected Medicaid nursing facility rate expenditures in step (3). In the event that aggregate Medicaid nursing facility rate expenditures exceed aggregate Medicaid nursing facility cost, the Medicaid nursing facility rate for each facility will be limited to the Medicaid cost based rate as determined in (2) above.

L. Payment Assistance

The Medicaid Agency will pay each Provider of nursing care services, who furnishes the services in accordance with the requirements of the State Plan, the amount determined for services furnished by the Provider under the Plan according to the methods and standards set forth in Section III of this attachment.

M. Upper Limits

1. The Medicaid Agency will not pay more than the provider's customary charge for private-pay patients except governmental facilities that provide services free or at a nominal charge. These facilities will be reimbursed on a reasonable cost related basis.
2. Any limitation on coverage of cost published under 42 CFR 413.30 and 413.35 will be applied to payments for long-term care facility services.

3. The cost of services, facilities and supplies furnished by organizations related by common ownership or control will not exceed the lower of the cost to the organization or the price of comparable services, facilities or supplies purchased elsewhere. The Medicaid Agency's cost report requires related organizations and costs to be identified and certified.
4. The Medicaid Agency may not pay more in the aggregate for long term care facility services than the amount that would be paid for the services under the Medicare principles of reimbursement. If it is determined that SCDHHS is paying more in the aggregate for long term care services, then the Medicaid rate for each facility will be limited to the Medicare rate retroactive to the beginning of the contract period. Upper Payment Limits will be calculated and tested against the following three groupings - State owned/operated; Non-state owned/operated governmental facilities; and Privately owned/operated facilities.

N. Provider Participation

Payments made under this State Plan are designed to enlist participation of a sufficient number of Providers of services in the program, so that eligible persons can receive the medical care and services included in the State Plan at least to the extent these are available to the general public. In accordance with the Balanced Budget Act of 1997, the state has provided for a public process in which providers, beneficiaries and their representatives, and other concerned state residents are given the reasonable opportunity to review and comment on the determination of rates under this plan.

O. Payment in Full

Participation in the program shall be limited to Providers of services who accept, as payment in full, the amounts paid in accordance with the provisions of this attachment for covered services provided to Medicaid recipients in accordance with 42 CFR 447.15.

P. Medicare Part A Coinsurance Days

Effective for dates of service beginning December 1, 2001, the South Carolina Department of Health and Human Services (SCDHHS) will no longer reimburse Medicaid contracting nursing facilities for Medicare Part A coinsurance days (Swing Bed Hospitals are exempted from this provision). Effective for dates of service beginning October 1, 2008, the SCDHHS will reimburse coinsurance payments applicable to Medicaid eligibles that qualify as a "Qualified Medicare Beneficiary (QMB) in accordance with the following payment methodology - the Medicaid payment will amount to the gross Medicaid rate/day less the amount paid by Medicare/day not to exceed the Medicare coinsurance rate/day.

Q. Certified Public Expenditures Incurred in Providing Nursing Facility Services and Intermediate Care Facilities for the Individuals with Intellectual Disabilities (ICF/IID) Services to Medicaid Eligibles.

The South Carolina Medicaid Agency uses the South Carolina Department of Health and Human Services (SCDHHS) Financial and Statistical Report for Nursing Homes for its Medicaid Program and all state owned/operated governmental nursing facilities must submit this report each year. The Agency will utilize pages thirteen (Summary of Revenue and Expense) and six (Census data) to determine the allowable cost of nursing facility services provided to Medicaid eligibles to be certified as public expenditures (CPE) when CPE is used as the source of state matching funds. Hospice room and board expenditures will not be covered in the CPE analysis as these expenditures are funded via intergovernmental transfers from state agencies. The Agency will use the procedures outlined below:

I. Interim Reconciliation of Interim Medicaid Nursing Facility Payments for State Owned/Operated Governmental Nursing Facilities When CPE is Used as the Source of State Matching Funds:

Upon receipt of the state owned/operated nursing facility's fiscal year end June 30 cost report, each nursing facility's interim Medicaid fee for service rate payments and any supplemental payments that may have been made which applied to services provided during the cost reporting period will be reconciled to its SCDHHS Financial and Statistical Report for Nursing Homes as filed to the Medicaid Agency for the respective cost reporting period.

Effective for services provided on or after October 1, 2012, the State will determine each SCDMH nursing facility's allowable Medicaid per diem cost (routine and covered ancillary) by summing the nursing facility allowable Medicaid routine and covered ancillary service cost centers and dividing this amount by total nursing facility days. The allowable Medicaid routine service and covered ancillary service costs will be derived from page 13, Summary of Revenue and Expense. Total nursing facility days will be obtained from page six (Census data). Next, in order to determine the allowable Medicaid nursing facility per patient day costs, Medicaid routine and covered ancillary service costs will be summed and divided by actual census days to determine the allowable Medicaid per patient day costs. Therefore, to determine allowable Medicaid nursing facility costs for each state owned/operated governmental nursing facility, the allowable Medicaid per diem cost will be multiplied by the number of Medicaid nursing facility days served during the cost reporting period.

During the annual certified public expenditure reconciliation process, the allowable Medicaid nursing facility costs as determined above will be compared to Medicaid payments received and applicable (including both fee for service, gross adjustments, and patient responsibility payments (i.e. patient recurring income)) to services provided during the cost reporting period. The Medicaid days and payments are tied to MMIS paid claims data (including gross adjustment payment data). In the event of an underpayment, the Agency will make no further payment to the provider. In the event of an overpayment, the Agency will recover only the federal portion of the overpayment. Any difference to the reimbursement amount

reflected above will be recorded as an adjustment on the CMS 64 report.

II. Final Reconciliation of Interim Medicaid Nursing Facility Payment Rate Post Reporting Year for State Owned/Operated Governmental Nursing Facilities When CPE is Used as the Source of State Matching Funds:

Upon issuance of a Final Audit Report by the Agency's audit contractor of the state owned/operated nursing facility cost reports, the Agency will determine each nursing facility's audited Medicaid allowable per diem cost by summing the nursing facility's routine service and covered ancillary service cost centers and dividing this amount by total nursing facility days. The routine service and covered ancillary service costs will be derived from the audited Summary of Revenue and Expense as reflected in the audit report. Total nursing facility days will represent audited census days as reflected in the audit report. Therefore, to determine each nursing facility's audited Medicaid nursing facility cost, the audited Medicaid per diem cost will be multiplied by Medicaid nursing facility days to determine the audited Medicaid nursing facility costs. The Medicaid days are tied to MMIS paid claims data. The Agency will compare the audited allowable Medicaid nursing facility costs against the Medicaid payments received and applicable (including fee for service, gross adjustments including CPE reconciliation adjustments, and patient responsibility payments (i.e. patient recurring income) to services provided during the cost reporting period. The Medicaid days and payments that will be used in the final audit settlement will be tied to MMIS paid claims (including gross adjustment payment data). In the event of an underpayment, the Agency will not make an additional payment. In the event of an overpayment, the Agency will recover only the federal portion of the overpayment. Any difference to the reimbursement amount reflected above will be recorded as an adjustment on the CMS 64 report.

III. Interim Reconciliation of Interim Medicaid Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) Payments When CPE is Used as the Source of State Matching Funds:

Upon receipt of the SCDDSN ICF/IID fiscal year end June 30 cost reports, each ICF/IID facility's interim Medicaid fee for service rate payments and any supplemental payments that may have been made which applied to services provided during the cost reporting period will be reconciled to its CMS Form 2552 cost report as filed to the Medicaid Agency for the respective cost reporting period.

The State will determine each of the SCDDSN ICF/IID's allowable Medicaid per diem cost by first identifying the allowable Medicaid routine cost and covered ancillary service costs included within the CMS Form 2552 cost report. This amount will be derived from the applicable lines for each provider as reflected on worksheet B, Part I, column 24. Each provider's patient days that will be used in the determination of the ICF/IID Medicaid per diem cost will be obtained from the Census data worksheets. Next, in order to determine each provider's allowable Medicaid cost, the Medicaid ICF/IID per diem cost will be multiplied by covered Medicaid ICF/IID days to determine



allowable Medicaid ICF/IID costs.

10/01/12

SC 12-027  
EFFECTIVE DATE:

RO APPROVED: 12/01/17  
SUPERSEDES: SC 11-025

During the annual certified public expenditure reconciliation process, each ICF/IID's allowable Medicaid costs as determined above will be compared to Medicaid payments received and applicable (including both fee for service, gross adjustments, and patient responsibility payments (i.e. patient recurring income) to services provided during the cost reporting period. In the event of an underpayment, the Agency will make no further payment to the provider. In the event of an overpayment, the Agency will recover only the federal portion of the overpayment. Any difference to the reimbursement amount reflected above will be recorded as an adjustment on the CMS 64 report.

Final Reconciliation of Interim Medicaid Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IIDs) Payment Rate Post Reporting Year When CPE is Used as the Source of State Matching Funds: Upon issuance of a Final Audit Report by the Agency's audit contractor of the SCDDSN ICF/IID cost reports, the Agency will determine each ICF/IID's audited Medicaid routine and covered ancillary service per diem cost by identifying the applicable line of the audited worksheet B, Part I, column 24 and dividing this amount by each ICF/IID's total patient days as identified from the audited Census data. To determine each ICF/IID's audited Medicaid cost, each ICF/IID's audited Medicaid per diem cost will be multiplied by covered Medicaid patient days to determine the audited Medicaid ICF/IID costs of each provider. The Medicaid days are tied to MMIS paid claims data. The Agency will then compare each ICF/IID's audited Medicaid costs against the Medicaid payments received and applicable (including both fee for service, gross adjustments including CPE reconciliation adjustments, and patient responsibility payments (i.e. patient recurring income) to services provided during the cost reporting period. The Medicaid days and payments, including claim and gross adjustment payments, that will be used in the final audit settlement will be tied to MMIS paid claims data. In the event of an underpayment, the Agency will not make an additional payment. In the event of an overpayment, the Agency will recover only the federal portion of the overpayment. Any difference to the reimbursement amount reflected above will be recorded as an adjustment on the CMS 64 report.

R. Allowability of Certain Costs

A) Auto Expense:

Allowable costs shall not include actual costs of administrative vehicles used for business purposes or regular vehicles used for patient care related activities (depreciation, maintenance, gas and oil, etc.). Allowable costs shall include administrative vehicle expense and regular vehicles expense used for patient care related activities only through documented business miles multiplied by the current mileage rate for the State of South Carolina employees.

Allowable costs shall include the actual costs of specialty vehicles (e.g., vans, trucks). These costs will be classified to the appropriate cost centers for Medicaid cost reporting purposes. Allowable costs would include operation, maintenance, gas and oil, and straight line depreciation (over a 5 year useful life). Should these specialty vehicles be made available for personal use of the facility employees, then that percentage of cost would be reclassified to nonallowable expense.

It is the intent of the SCDHHS to recognize as specialty vehicles, station wagons with a seating capacity of more than six (6) passengers used in patient care related activities, vans, and trucks. The cost of sedans or station wagons with a seating capacity of six (6) or less passengers used for patient transport or other patient care related activities will be limited to the state employee mileage rate and charged to the appropriate cost center(s) based upon miles documented by a log effective August 1, 1986.

For cost reporting requirements prior to August 1, 1986, actual allowable costs which would include operation, maintenance, gas and oil, and straight-line depreciation (over a 5 year useful life and limited to 10,000 maximum vehicle cost) will be used in determining allowable costs for cost centers other than administration. Should these specialty vehicles be made available for personal use of the facility employees, then that percentage of cost would be reclassified to nonallowable expense.

Any vehicle that cannot be identified to charge to the appropriate cost center will be charged to administration and follow administration vehicle allowable cost guidelines. However, only that portion of such costs related directly to patient care related purposes will be allowed.

B) Dues

Association dues will be recognized for reimbursement purposes only when the dues are for professional services that are patient care related. Any component of association dues related to legal actions against state agencies, lobbying, etc., will not be recognized as an allowable cost for Medicaid rate setting purposes.

C) Legal Fees

For rates effective October 1, 2006, allowable Medicaid reimbursable costs include reasonable legal fees arising from normal day-to-day business activities related to patient care as defined in HIM-15. Any legal fees recognized as allowable Medicaid costs must be demonstrated to be necessary for the efficient delivery of needed health care services provided by the facility.

Other legal charges including, but not limited to, those incurred in administrative appeals and/or litigation involving state or federal agencies will not be considered an allowable cost for Medicaid rate setting purposes. However, reasonable legal fees incurred in administrative appeals of audit exceptions may be refundable through an adjustment outside of the rate setting system. The amount of the adjustment shall be determined by the Agency Hearing Panel, upon documentation, but shall not exceed fifteen percent of the amount recovered through appeals or \$1,000, whichever is lower. Additionally, retainer fees would not be considered an allowable cost.

D) Travel

Patient care related travel will be recognized in accordance with South Carolina state employees per diem and travel regulations. Out-of-state travel will be limited to the 48 states located within the continental United States. Further, such out-of-state travel must be either the reasonable allocable portion of cost for chain facilities with out-of-state offices; or (1) be for the purpose of meeting continuing education requirements and (2) must be to participate in seminars or meetings that are approved for that purpose by the South Carolina Board of Examiners for Nursing Home Administrators. Allowable cost for attendance at out-of-state meetings and seminars will be limited to two trips per year per facility. Also, out-of-state travel does not include travel to counties bordering the State of South Carolina. Effective for July 1, 1990 payment rates, travel to the following states/areas are treated as in-state travel, and thus are not subject to the limits on out-of-state travel: Georgia, North Carolina, Washington D.C., and Baltimore, Maryland.

E) Director Fees

Director fees and costs associated with attending board meetings or other top management responsibilities will not be allowed. However travel to and from the directors meetings will be allowed at the per mile rate for state employees and will be limited to in-state travel.

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)	\$77,771	\$82,347	\$102,482
RN	\$58,822	\$59,592	\$62,816
LPN	\$48,006	\$48,006	\$50,149
CNA	\$24,336	\$24,336	\$26,000
SOCIAL SERVICES DIRECTOR	\$39,874	\$41,434	\$51,522
SOCIAL SERVICES ASSISTANT	\$34,050	\$34,050	\$39,790
ACTIVITY DIRECTOR	\$33,030	\$33,883	\$36,795
ACTIVITY ASSISTANT	\$22,027	\$22,464	\$24,586
DIETARY SUPERVISOR	\$40,456	\$44,762	\$55,245
DIETARY WORKER	\$19,781	\$20,966	\$23,754
LAUNDRY SUPERVISOR	\$29,099	\$29,099	\$29,099
LAUNDRY WORKER	\$17,597	\$19,344	\$21,590
HOUSEKEEPING SUPERVISOR	\$28,746	\$34,674	\$38,438
HOUSEKEEPING WORKER	\$18,366	\$19,282	\$20,987
MAINTENANCE SUPERVISOR	\$38,355	\$42,848	\$50,773
MAINTENANCE WORKER	\$28,018	\$28,122	\$31,429
ADMINISTRATOR	\$89,752	\$101,213	\$131,581
ASSISTANT ADMINISTRATOR	\$65,644	\$77,958	\$77,958
BOOKKEEPER / BUSINESS MGR	\$45,302	\$45,302	\$47,715
SECRETARY / RECEPTIONIST	\$28,413	\$28,704	\$30,035
MEDICAL RECORDS SECRETARY	\$36,192	\$36,192	\$36,192

Note: Based upon payroll surveys sent during the FYE 10/1/15 to 9/30/16

SC 17-0016  
EFFECTIVE DATE: 10/01/17  
RO APPROVED: 11/07/17  
SUPERSEDES: SC 15-008

1. The above are maximum limits of allowable compensation to owners and/or relatives who are actually performing these duties 100% of a normal work week. Part-time performance will be computed on percentage of time spent. No individual will have more than one full time equivalent (40 hours per week) job recognized in the Medicaid program.
2. If the facility has under 60 beds, only (1) Administrator and/or Business Manager is allowed.
3. Allowances for any position not specifically listed herein will be based on comparable positions.
4. Other items of consideration to be used in adjustments to these maximum allowances are:
  - a. Determination that the job is necessary and that the person is actually there 40 hours per week. (The owner/lessee must document that the job is necessary, and the relative actually worked on the premises the number of hours claimed.)
  - b. The time period during which these duties were performed.
  - c. Accounting period bed changes based on dates of change.
5. Allowable compensation amounts shown above will be adjusted annually by annual cost of living raises provided to state employees.
6. For clarification purposes, owners and/or relatives will be defined as an individual, individuals, or any legal entity with ownership or equity of at least five percent (5%) in the provider.

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	
					130%* 100+ admin. Guidelines	
CEO	see nh admin. Guidelines	\$89,752	\$101,213	\$131,581		\$171,055
ASST CEO CONTROLLER CORPORATE SECRETARY CORPORATE TREASURER ATTORNEY	75%	\$67,314	\$75,910	\$98,686		\$128,291
ACCOUNTANT BUSINESS MGR PURCHASING AGENT REGIONAL ADMINISTRATOR REGIONAL V-P REGIONAL EXECUTIVE	70%	\$62,826	\$70,849	\$92,107		\$119,739
CONSULTANTS: SOCIAL ACTIVITY DIETARY (RD) PHYSICAL THER (RPT) MEDICAL RECORDS (RRA) NURSING (BSRN)	65%	\$58,339	\$65,788	\$85,528		\$111,186
SECRETARIES	see nh	\$28,413	\$28,704	\$30,035		\$30,035
BOOKKEEPERS	see nh	\$45,302	\$45,302	\$47,715		\$47,715
MEDICAL DIRECTOR	90%	\$80,777	\$91,092	\$118,423		53,950

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

Note: Based upon payroll surveys sent during the FYE 10/1/15 to 9/30/16

1. 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.
2. No assistant operating executive will be authorized for a chain with 257 beds or less.

SC 17-0016  
EFFECTIVE DATE:10/01/17  
RO APPROVED: 11/07/17  
SUPERSEDES: SC 15-008

3. Allowable compensation amounts shown above will be adjusted annually by annual cost of living raises provided to state employees.

H) Management Fee

Only reasonable management fees which result in lower total costs shall be included in allowable costs. Each centrally managed facility shall submit a home office cost report which separately identifies each cost by cost categories. The costs so identified will be individually tested for reasonableness and then assigned to the appropriate line item in the individual facility's cost report.

For purposes of setting the current administrative cost standards, the administrative costs of those centrally managed facilities that reported their management fee as a single line item among administrative costs in their cost report shall be excluded from the computation of the administrative standard. Those centrally managed facilities which identified their management fee as a single line item among administrative costs shall have the management fee included in administrative cost for the purpose of rate calculation.

I) Other Benefits

The other benefits such as pensions, group life insurance, and health insurance can be recognized if these benefits are provided in accordance with sound financial/management practices by the provider. This excludes from allowable cost Key Man Life Insurance and benefits made available only to an exclusive number of employees, including the owner of the facility. Other benefits are accumulated to applicable cost centers.

J) Payroll Taxes and Benefits

Payroll taxes and benefits should be reported in the cost center applicable for the salaries to which they relate. Payroll taxes and benefits will be limited in the same proportion that compensation is limited.

K) Routine Laundry Services

Effective October 1, 1993, basic personal laundry services are to be provided to all patients of the facility free of charge. All laundry costs associated with basic patient personal laundry will be included in allowable costs in the laundry cost center. Therefore, for clarification purposes, there should be no reduction in allowable costs via a step-down or income offset for the provision of basic personal laundry services regardless of whether or not a charge is made for this service. Basic personal laundry does not include dry cleaning, mending, hand washing or other specialty services; these services need not be provided and residents may be charged for such services if they request them.



L) Ancillary Services Reimbursement

Ancillary services provided to Medicaid recipients are allowable costs and thus are reimbursable under both the Medicare and Medicaid Programs. While Medicaid reimburses ancillary services as part of the overall routine per diem rate, Medicare reimburses the direct cost of ancillary services through either Part A consolidated billing or Part B. Therefore, in order to ensure that the Medicaid rate of each contracting nursing facility provides reimbursement for covered ancillary services provided solely to Medicaid eligible recipients residing in nursing facilities, the Medicaid Agency will include only the costs of the Medicaid recipients' ancillary services which are not reimbursed by Medicare consolidated billing, Medicare Part B, or other payors in the Medicaid reimbursement rate. Only the direct cost of ancillary services will be excluded from allowable Medicaid cost.

Examples of ancillary services include physical therapy, speech therapy, occupational therapy, specialty beds, and other special items and services for which charges are customarily made in addition to a routine service charge. For further clarification of routine services versus ancillary services, providers should refer to the Provider Reimbursement Manual HIM-15, Sections 2203 through 2203.2. However, please note that while the cost of diabetic testing supplies is categorized as an ancillary service per HIM-15, the Medicaid Agency will consider this cost to be a nursing supply for Medicaid rate setting purposes.

For state operated long term care facilities, no adjustment to the Medicaid rate will be made to ancillary services (including specialty beds) to adjust for dual reimbursement by both the Medicare and Medicaid Programs. Instead the agency will recoup all dually eligible covered Part B ancillary services billed and recovered during its annual cost report period which ends June 30.

Pursuant to the above, it shall be the responsibility of the provider to implement a uniform charge structure and bill Medicare and other payors for the reimbursement of covered ancillary services provided to Medicaid eligible recipients. Failure to implement billing procedures will result in a downward adjustment to allowable cost.

M) Eden Alternative Expenses

The costs incurred by nursing facilities which participate in adopting the Eden Alternative concept will be considered an allowable cost for Medicaid rate setting purposes. The goals of the Eden Alternative are to improve the quality of life in nursing facilities, and transform the conventional nursing facility into a vibrant human habitat for its residents. The incorporation of gardens, animals, birds, and children into the daily activities of the nursing facility residents assists in meeting these goals.

As with all other allowable Medicaid costs, these costs will be subject to reasonableness and must be related to patient care. Additionally, Eden Alternative expenses must be offset by grant income. Costs associated with fund raising activities applicable to the Eden Alternative concept or any other fund raising program will not be considered an allowable cost for Medicaid rate setting purposes.

N) Quality Initiatives Grant Awards

The goal of the Quality Initiatives Grant Award Program administered by the Medicaid Agency is to enhance the quality of care and quality of life for nursing facility residents and staff through initiatives that focus on education. Nursing facilities that participate in this Quality Initiative Program will receive grant funding that must be used to fund one of the approved quality enhancing initiative items: (1) subscription costs related to "My Inner View", an independent survey and benchmarking company measuring quality in long-term care and assisted living facilities; (2) Bladder Scanner, or (3) Electronic Medical Records System. While the costs of the items listed above will be included as an allowable cost for Medicaid rate setting, nursing facilities must offset the costs of these items by the amount of the grants award received from the Medicaid Agency.

O) Professional Liability, Workers' Compensation, and Health Insurance Costs

A provider participating in the South Carolina Medicaid Program is expected to follow sound and prudent management practices, including the maintenance of an adequate insurance program to protect itself against likely losses, particularly losses so great that the provider's financial stability would be threatened. There are various types of insurance coverage that are allowable costs for South Carolina Medicaid reimbursement purposes and they, as well as their allowable cost requirements, are defined in the Provider Reimbursement Manual HIM-15, sections 2161 through 2162.14. However, due to recent questions relating to providers' treatment of professional liability, workers' compensation, and health insurance costs, the South Carolina

Department of Health and Human Services (SCDHHS) is providing the following clarification/new policy to address the questions raised for the three insurance programs.

The provider may choose to protect itself against professional liability, workers' compensation, and health insurance costs through the use of one of the following methods:

1. Insurance purchased from a commercial insurance company which provides coverage after a deductible or coinsurance provision has been met;
2. Insurance purchased from a limited purpose insurance company (captive);
3. Total self insurance; or
4. A combination of purchased insurance and self-insurance.

In order for the losses and the costs associated with the purchase of insurance coverage to be considered as an allowable cost for South Carolina Medicaid reimbursement purposes, all pertinent provisions of the Provider Reimbursement Manual HIM-15 must be met. This would include those sections of HIM-15 relating to losses arising from other than sale of assets (i.e. all sections of 2160 through 2160.5) and those sections of HIM-15 relating to insurance (i.e. all sections of 2161 through 2162.14). In addition, the state will clarify existing requirements and impose new requirements effective October 1, 2007:

- No more than twelve months of claims expense will be allowed during a full cost reporting period;
- Professional liability punitive damage awards are not considered an allowable cost for South Carolina Medicaid reimbursement purposes.
- Effective October 1, 2007, free standing nursing facilities as well as chain nursing facilities must ensure that South Carolina specific data is used in claiming allowable insurance costs for its South Carolina nursing facilities.
- For cost reporting periods beginning on or after October 1, 2007, when a change is made from commercial insurance to one of the alternatives listed above or from one alternative to another, the provider must document and submit to the SCDHHS a comparative analysis which shows that the provider's choice results in a reasonable cost for the coverage offered and that the extent of the coverage is consistent with sound management practices. The provider's comparative analysis must be performed every three (3) years to assure consistent

application of the prudent buyer principle and to properly monitor the cost effectiveness of the insuring method being applied. The provider must provide these analyses for review by the SCDHHS and/or the Office of the State Auditor (SAO). The analyses must include the information as reflected in HIM-15, section 2162.C.

- Providers that are currently operating under insurance coverage other than commercial insurance are required to perform a comparative analysis every three (3) years to assure consistent application of the prudent buyer principle and to properly monitor the cost effectiveness of the insuring method being applied. The provider must provide these analyses for review by the SCDHHS and/or the SAO. The analyses must include the information as reflected in HIM-15, section 2162.C. An insurance survey will be mailed to all contracting providers no later than March 31, 2008 to determine those providers that will be required to perform the comparative analysis and when it will be due.
- Effective October 1, 2007, providers cannot switch between claims paid and claims paid with incurred but not reported expenses (IBNR) factor without prior authorization from the SCDHHS.

#### Insurance Purchased from a Commercial Insurance Company

The reasonable costs of insurance purchased from a commercial carrier are allowable if the type, extent, and cost of coverage are consistent with sound management practice (HIM-15, sections 2161.A., 2162.1, 2160.B). The premiums paid under this coverage will be an allowable cost for South Carolina Medicaid reimbursement purposes using GAAP and HIM -15 reimbursement principles to allocate the expense between cost reporting periods.

#### Insurance Purchased from a Limited Purpose Insurance Company (Captive)

See HIM-15, section 2162.2 for South Carolina Medicaid allowable cost reimbursement requirements.

#### Total Self-Insurance

A provider must meet all of the conditions set forth in HIM-15, section 2162.7 to be designated as "self-insured" by the South Carolina Medicaid Program. Under this designation, providers will be required to claim as cost the actuarial determined amount to be paid into the fund in accordance with HIM-15. Expenses related to losses paid out of the self-insurance fund as described in HIM-15, section 2162.8 will be considered an allowable cost for South Carolina Medicaid reimbursement purposes. Those expenses specifically identified in section 2162.8 will become part of the cost of the particular insurance coverage that meets the self-

insurance test while those not specifically identified will be considered an administrative cost. Assuming that a nursing facility employs a Medicaid allowable self-insurance plan as defined in the State Plan, a retrospective settlement review will be performed to ensure that Medicaid appropriately reimbursed the provider when one of the following situations occur:

- The nursing facility converts from a self-insurance plan to a commercial insurance plan or;
- A sale or lease of a nursing facility occurs and the prior owner/lessor employed a self-insurance plan or;
- The nursing facility terminates participation in the SC Medicaid Program.

The retrospective settlement review process will include the review of provider contributions into the self-insurance plan, the actual claims history of the services reimbursed via the self-insurance plan, and the Medicaid utilization rate(s) of the nursing facility. In the event of an underpayment, the Medicaid Agency will reimburse the nursing facility via a gross adjustment. In the event of an overpayment, the nursing facility will be required to repay the Medicaid Agency the overpayment amount.

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 losses 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.

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**EFFECTIVE DATE: 10/01/14**  
**RO APPROVED: 10/24/14**  
**SUPERSEDES: SC 11-006**

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. Effective October 1, 2016, 100% 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.

Enclosure 4

Attachment 4.19 D

The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

Approval Date 3/6/98  
Effective Date: 10/01/97

Plan # 97-008  
Supersedes Plan # N/A