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**State/Territory Name: South Carolina**

**State Plan Amendment (SPA) #: 11-025**

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS 179 Form
- 3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard, Mail Stop 62-2.6-12  
Baltimore, Maryland 21244-1850



## **Centers for Medicaid and CHIP Services**

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MAR 6, 2012

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

RE: State Plan Amendment SC 11-025

Dear Mr. Keck:

We have reviewed the proposed amendment to Attachment 419-D of your Medicaid State plan submitted under transmittal number (TN) 11-025. Effective November 1, 2011 this amendment proposes to revise the payment methodology for Nursing Facility Care services. Specifically, this amendment proposes to update the deemed asset value and market rate of return used in the cost of capital calculation; update cost center standards for payment rate determination; eliminate rate increases; reduce rates effective October 1, 2010 by 3.02%; and remove non-state government facilities from the certified public expenditure reimbursement methodology.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a), 1902(a)(13), 1902(a)(30), 1903(a) and 1923 of the Social Security Act and the implementing Federal regulations at 42 CFR Part 447. We have found that the proposed changes in payment methodology comply with applicable requirements and therefore have approved them with an effective date of November 1, 2011. We are enclosing the CMS-179 and the amended approved plan pages.

If have any questions, please call Stanley Fields at (502) 223-5332.

Sincerely

//s//

Cindy Mann  
Director, CMCS

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b>		1. TRANSMITTAL NUMBER: SC 11-025	2. STATE South Carolina
<b>FOR: HEALTH CARE FINANCING ADMINISTRATION</b>		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE November 1, 2011	
5. TYPE OF PLAN MATERIAL ( <i>Check One</i> ):  <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT			
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT ( <i>Separate Transmittal for each amendment</i> )			
6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR, Subpart C		7. FEDERAL BUDGET IMPACT: The November 1, 2011 payment rates were calculated to be budget neutral.  a. FFY 2012                      \$-0- b. FFY 2013                      \$-0-	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:  Attachment 4.19-D, Pages 6, 8, 13, 14, 15, 17, 18, 23, 25, 30 through 30e		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT ( <i>If Applicable</i> ):  Attachment 4.19-D, Pages 6, 8, 13, 14, 15, 17, 18, 23, 25, & 30	
10. SUBJECT OF AMENDMENT: Nursing facility rate update effective November 1, 2011 based upon annual rebasing .			
11. GOVERNOR'S REVIEW ( <i>Check One</i> ): <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input checked="" type="checkbox"/> OTHER, AS SPECIFIED: <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED                      Mr. Keck was designated by the Governor <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL                      to review and approve all State Plans			
12. SIGNATURE OF STATE AGENCY OFFICIAL: //s//		16. RETURN TO:  South Carolina Department of Health and Human Services Post Office Box 8206 Columbia, SC 29202-8206	
13. TYPED NAME: Anthony E. Keck			
14. TITLE: Director			
15. DATE SUBMITTED: December 20, 2011			
<b>FOR REGIONAL OFFICE USE ONLY</b>			
17. DATE RECEIVED: 12-21-11		18. DATE APPROVED: 03/06/12	
PLAN APPROVED – ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: 11/12/11		20. SIGNATURE OF REGIONAL OFFICIAL: //s//	
21. TYPED NAME: Cindy Mann		22. TITLE: Director, CMS	
23. REMARKS:			

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 Division of Research and Statistics of the Budget and Control Board, based on latest data published by the Federal Reserve. Effective November 1, 2011, this rate is 4.20%.

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

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RO APPROVED: MAR -6 2012

SUPERSEDES: SC 10-006

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

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

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SUPERSEDES: SC 11-006

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

PATIENT DAYS USED: 0 MAXIMUM BED DAYS: 0  
 PATIENT DAYS INCURRED: 0  
 TOTAL PROVIDER BEDS: 0 ACTUAL OCCUPANCY %: 0.00  
 % LEVEL A 0.000 PATIENT DAYS @ 0.96 0

COMPUTATION OF REIMBURSEMENT RATE - PERCENT SKILLED METHODOLOGY
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	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	0.00%			0.00
COST OF CAPITAL				0.00
PROFIT INCENTIVE (MAX 3.5% OF ALLOWABLE COST)			3.50%	0.00
COST INCENTIVE - FOR GENERAL SERVICE, DIETARY, LHM				0.00
EFFECT OF \$1.75 CAP ON COST/PROFIT INCENTIVES			\$1.75	0.00
SUBTOTAL				0.00
ADJUSTMENT FACTOR		3.02%		0.00
REIMBURSEMENT RATE				0.00

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

0 Through 60 Beds  
61 Through 99 Beds  
100 Plus Beds

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

1. General Services:

- a. Accumulate all allowable cost for the General Services cost center (Nursing & Restorative) for all facilities in each bed size.
- b. Determine total patient days by multiplying total beds for all facilities in each group by (365 x 96%).
- 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

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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.

4. For costs not subject to standards, the cost determined in step 2 will be allowed in determining the facility's rate.
5. Accumulate costs determined in steps 3 and 4.
6. Inflate the cost in step 5 by multiplying the cost in step 5, by the inflation factor. The maximum inflation factor that can be used will be that provided by the State of South Carolina Division of Research and Statistical Services and is determined as follows:
  - a. Proxy indices for each of the eleven major expenditure components of nursing homes, (salaries, food, medical supplies, etc.) during the third quarter of 2011 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 2011.
  - 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 2012 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 2012.
  - c. The percent change in the total proxy index during the third quarter of 2011 (as calculated in step a), to the total proxy index in the third quarter of 2012 (as calculated in step b), was 3.6%. Effective November 1, 2011 the inflation factor used was 0.0%.
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 96% occupancy, actual days will be adjusted to reflect 96% 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:

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- a. Administration and Medical Records & Services -  
100% of difference with no limitation.

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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. Prior to the adjustment factor being applied, the reimbursement rate under this concept will be the total of costs accumulated in step 6, cost of capital, cost incentive and profit.
11. For rates effective for services provided on and after November 1, 2011, the provider's reimbursement rate calculated in step 10 will be decreased by the 3.02% adjustment factor.

D. Payment for Hospital-based and Non-profit Facilities

Hospital-based and non-profit facilities will be paid in accordance with Sections III A, B, and C.

E. Payment determination for a new facility, replacement facility, change of ownership through a purchase of fixed assets, change of ownership through a lease of fixed assets, when a facility changes its bed capacity by more than fifty percent (50%), or when temporary management is assigned by the state agency to run a facility.

1. Payment determination for a new facility or a facility that changes its bed capacity by more than fifty percent (50%):

The following methodology shall be utilized to determine the rate to be paid to a new facility or a facility that changes its bed capacity by more than fifty percent (50%):

Based on a six (6) month's projected budget of allowable costs covering the first six months of the Provider's operation under the Medicaid program, the Medicaid agency will set an interim rate to cover the first six (6) months of operation or through the last day of the sixth (6<sup>th</sup>) full calendar month of operation. The same rate setting methodology previously described will be applied to the provider's allowable costs in determining the rate

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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

Because State Government facilities operate on budgets approved by the General Assembly and overseen by the Budget and Control Board, State Government nursing facilities and long term care IMD's will be paid retrospectively their total allowable costs subject to the allowable cost definitions set forth in this plan effective October 1, 1989. Effective October 1, 1991, allowable costs will include all physician costs, excluding the professional component side of physician cost. The professional component side will be billed separately under the physician services line of the South Carolina Medicaid Program. See Section Q which describes the certified public expenditures review process and retrospective cost settlement process for state owned/operated nursing facilities.

G. Payment Determination for ICF/MR's

1. All ICF/MR'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/MR 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/MR'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/MR'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.
3. ICF/MR's will be reimbursed on a retrospective cost related basis as determined in accordance with Medicare (Title XVIII) Laws, Regulations, and Policies adjusted for services covered by Medicaid (Title XIX).

Items of expense incurred by the ICF/MR 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.

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- k) Speech and hearing services as described in 42 CFR \$483.430(b) (1) and (b) (5) (vii).
- l) Food and nutritional services as described in 42 CFR \$483.480.
- m) Safety and sanitation services as described in 42 CFR \$483.470(a), (g) (3), (h), (i), (j), (k), and (l).
- n) Physician services as described in 42 CFR \$483.460(a).

Any service (except for physician services) that is required of an ICF/MR facility that is reimbursable under a separate Medicaid program area must be billed to the respective program area. Any costs of this nature cannot be claimed in the Medicaid cost report.

- 4. See Section Q which describes the certified public expenditure review process and retrospective cost settlement process for state owned/operated ICF/MRs. 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).
- 5. The Medicaid Agency will not pay more than the provider's customary charge except governmental facilities that provide services free or at a nominal charge. Reimbursement to governmental facilities will be limited in accordance with 42 CFR \$447.271(b).

#### H. Payment for Swing-Bed Hospitals

Effective July 1, 1989, the South Carolina Medicaid Program will participate in the provision of nursing facility services in swing bed hospitals. A rate will be determined in accordance with the payment methodology as outlined in this state plan, adjusted for the following conditions:

- A) Effective October 1, 1992, all nursing facilities in operation will be used in the calculation of the rate.
- B) The rate excludes the cost associated with therapy services.
- C) The rate reflects a weighted average rate using the state's prior FYE June 30 Medicaid permit days. Effective July 1, 1991, projected Medicaid days were used.

#### 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

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SUPERSEDES: SC 11-021

Q. Certified Public Expenditures Incurred in Providing Nursing Facility Services and Intermediate Care Facilities for the Mentally Retarded (ICF/MR) 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). 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 :

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.

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 interim retrospective cost settlement 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 reimburse the provider only the federal portion of the underpayment. 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:

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 interim retrospective cost settlements, 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 reimburse the provider only the federal portion of the underpayment. 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 the Mentally Retarded (ICF/MR) Payments:

Upon receipt of the SCDDSN ICF/MR fiscal year end June 30 cost reports, each ICF/MR 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 2552-96 cost report as filed to the Medicaid Agency for the respective cost reporting period.

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The State will determine each of the SCDDSN ICF/MR's allowable Medicaid per diem cost by first identifying the allowable Medicaid routine cost and covered ancillary service costs included within the CMS Form 2552-96 cost report. This amount will be derived from the applicable lines for each provider as reflected on worksheet B, Part I, column 21. Each provider's patient days that will be used in the determination of the ICF/MR 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/MR per diem cost will be multiplied by covered Medicaid ICF/MR days to determine allowable Medicaid ICF/MR costs.

During the interim retrospective cost settlement process, each ICF/MR'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 reimburse the provider only the federal portion of the underpayment. 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 the Mentally Retarded (ICF/MRs) Payment Rate Post Reporting Year: Upon issuance of a Final Audit Report by the Agency's audit contractor of the SCDDSN ICF/MR cost reports, the Agency will determine each ICF/MR's audited Medicaid routine and covered ancillary service per diem cost by identifying the applicable line of the audited worksheet B, Part I, column 21 and dividing this amount by each ICF/MR's total patient days as identified from the audited Census data. To determine each ICF/MR's audited Medicaid cost, each ICF/MR's audited Medicaid per diem cost will be multiplied by covered Medicaid patient days to determine the audited Medicaid ICF/MR costs of each provider. The Medicaid days are tied to MMIS paid claims data. The Agency will then compare each ICF/MR's audited Medicaid costs against the Medicaid payments received and applicable (including both fee for service, gross adjustments including interim retrospective cost settlements, 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 reimburse the provider only the federal portion of the underpayment. 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.

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