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State/Territory Name: South Carolina

State Plan Amendment (SPA) #: 14-020

This file contains the following documents in the order listed:

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

Financial Management Group

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 14-020

Dear Mr. Keck:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid state plan submitted under transmittal number (TN) 14-020. Effective October 1, 2014 this amendment modifies the State's reimbursement methodology for setting payment rates for nursing facility services. Specifically, the following changes are being proposed: update asset value and market rate of return used in capital payment determination; update cost center standards; increase payment rates by 3.3%; eliminate budget neutrality factor; revise payment method for change of ownership or lease of fixed assets to purchaser; and require retrospective cost settlement for providers that self-fund liability insurance if they change to purchasing commercial insurance or sell the nursing facility.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a), 1902(a)(13), 1902(a)(30), and 1903(a) of the Social Security Act and the implementing Federal regulations at 42 CFR Part 447. We have found that the proposed changes in payment methodology comply with applicable requirements and therefore have approved them with an effective date of October 1, 2014. We are enclosing the CMS-179 and the amended approved plan pages.

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

Sincerely,

//s//

Timothy Hill
Director

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: SC 14-020

2. STATE: South Carolina

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
October 1, 2014

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR, Subpart C

7. FEDERAL BUDGET IMPACT: ($23.20 million x 70.64%)
a. FFY 2015 $16.39 million
b. FFY 2016 $Rates will be rebased

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-D, pages 6, 8, 14, 17, 18, 20, 21, 22, 26a, 40, & 40a (new page)

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

Attachment 4.19-D, pages 6, 8, 14, 17, 18, 20, 21, 22, 26a, & 40

10. SUBJECT OF AMENDMENT:
Nursing Facility Rate Updates Effective October 1, 2014

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Mr. Keck was designated by the Governor to review and approval all state plans.

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Anthony E. Keck

14. TITLE:
Director

15. DATE SUBMITTED:
August 14, 2014

16. RETURN TO:

South Carolina Department of Health and Human Services
P.O. Box 8206
Columbia, South Carolina 29202-8206

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 08/15/14

18. DATE APPROVED: 10/24/14

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 10/01/14

20. SIGNATURE OF REGIONAL OFFICIAL:
//s//

21. TYPED NAME:

22. TITLE:

23. REMARKS:

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

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

The plan uses the index for the rental value of a home computed as part of the CPI as the appropriate measure for approximating the increase in the value of nursing home assets in South Carolina since 1980-1981. This index measures the increase in the amount that homeowners on average could get for renting their homes. For the period from 1980-1981 through the federal cost year 2012-2013, this index rose 227.359 percent.

Inflating the base period market value of $15,618 by the index for homeowner's rent, the "Deemed Asset Value" for cost year 2012-2013 is $51,127 per bed and will be used in the determination of nursing facility rates beginning October 1, 2014.

3) Calculation of "Deemed Depreciated Value"

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

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

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

The plan sets the rate of return for a fiscal year at the average of rates for thirty year Treasury bonds for the latest three completed calendar years prior to the fiscal year, as determined by the Division of Research and Statistics of the Budget and Control Board, based on latest data published by the Federal Reserve. Effective October 1, 2014, this rate is 3.43%.

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

5) Additions To Facilities After 1981

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

6) Computation of Cost of Capital

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

PROVIDER NAME:	0				
PROVIDER NUMBER:	0				
REPORTING PERIOD:	10/01/12	through	09/30/13	DATE EFF.	10/01/14

	MAXIMUM BED DAYS:			0
PATIENT DAYS USED:	0	PATIENT DAYS INCURRED:		0
TOTAL PROVIDER BEDS:	0	ACTUAL OCCUPANCY %:	0.00	
% LEVEL A	0.000	PATIENT DAYS @	0.92	0

COMPUTATION OF REIMBURSEMENT RATE - PERCENT SKILLED METHODOLOGY

		PROFIT INCENTIVE	TOTAL ALLOW COST	COST STANDARD	COMPUTED RATE
COSTS SUBJECT TO STANDARDS:					
GENERAL SERVICE			0.00	0.00	
DIETARY			0.00	0.00	
LAUNDRY/HOUSEKEEPING/MAINT.			0.00	0.00	
SUBTOTAL		0.00	0.00	0.00	0.00
ADMIN & MED REC		0.00	0.00	0.00	0.00
SUBTOTAL		0.00	0.00	0.00	0.00
COSTS NOT SUBJECT TO STANDARDS:					
UTILITIES			0.00		0.00
SPECIAL SERVICES			0.00		0.00
MEDICAL SUPPLIES AND OXYGEN			0.00		0.00
TAXES AND INSURANCE			0.00		0.00
LEGAL COST			0.00		0.00
SUBTOTAL			0.00		0.00
GRAND TOTAL			0.00		0.00
INFLATION FACTOR	3.30%				0.00
COST OF CAPITAL					0.00
PROFIT INCENTIVE (MAX 3.5% OF ALLOWABLE COST)				3.50%	0.00
COST INCENTIVE - FOR GENERAL SERVICE, DIETARY, LHM					0.00
EFFECT OF $1.75 CAP ON COST/PROFIT INCENTIVES				$1.75	0.00
SUBTOTAL					0.00
ADJUSTMENT FACTOR			0.0000%		0.00
REIMBURSEMENT RATE					0.00

SC: 14-020
EFFECTIVE DATE: 10/01/2014
RO APPROVED: OCT 24 2014
SUPERSEDES: SC 13-010

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 2014 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 2014.

   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 2015 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 2015.

   c. The percent change in the total proxy index during the third quarter of 2014 (as calculated in step a), to the total proxy index in the third quarter of 2015 (as calculated in step b), was 3.30%. Effective October 1, 2014 the inflation factor used was 3.30%.

7. The per patient day cost of capital will be calculated by dividing capital cost as determined under I.(F)(c) of this plan by actual patient days. However, if the facility has less than 92% occupancy, actual days will be adjusted to reflect 92% occupancy.

8. Cost Incentive - General Services, Dietary, and Laundry, Housekeeping, and Maintenance

   If the facility's actual allowable costs for these three cost centers are below the sum of these three allowable cost standards, the facility will be eligible for a cost incentive of an amount equal to the difference between the sum of the standards and the sum of the facility's actual costs, up to 7% of the sum of the standards.

9. Profit will be allowed if the provider's allowable cost is lower than the standard as follows:

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

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 reimbursement rate will be the total of costs accumulated in step 6, cost of capital, cost incentive and profit.

ayment 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^{th}) full calendar month of operation. The same rate setting methodology previously described will be applied to the provider's allowable costs in determining the rate

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^{th}) full calendar month of operation. The same rate setting methodology previously described will be applied to the provider's allowable costs in determining the rate 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.

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 (1st) day of the seventh (7th) 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.

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.

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.

(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

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.

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

Professional Liability Expense Only - Pool Payments

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

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