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State/Territory Name: South Carolina

State Plan Amendment (SPA) #: 19-0001

This file contains the following documents in the order listed:

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

Financial Management Group

August 28, 2019

Joshua D. Baker, Director
Department of Health & Human Services
1801 Main Street
Columbia, SC 29201

RE: State Plan Amendment (SPA) 19-0001

Dear Mr. Baker:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number 19-0001. This amendment proposes to modify reimbursement for ICF-IID facilities. Specifically, this amendment proposes to rebase rates based on each facility's fiscal year 2016 cost reports. Current rates are based on 2012 cost reports. In addition, the amendment will provide an increase in direct care worker salaries as approved by the Legislative Session.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a), and 1923 of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C. We have found that the proposed reimbursement methodology complies with applicable requirements and therefore have approved them with an effective date of April 1, 2019. We are enclosing the CMS-179 and the amended approved plan pages.

If you have any questions, please call Anna Dubois at (850) 878-0916.

Sincerely,

/s/

Kristin Fan
Director

cc:
Anna Dubois
Dan Yablochnikov

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: 19-0001

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
April 1, 2019

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:
a. FFY 2019 $ 1.93 million ($5.43 million * .7122 x 50%)
b. FFY 2020 $ 3.84 million ($5.43 million * .7070)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-D, pages 23, 23a

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-D, pages 23, 23a

10. SUBJECT OF AMENDMENT:
April 1, 2019 ICF/IID Rates

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

12. SIGNATURE OF STATE AGENCY OFFICIAL:
/s/

13. TYPED NAME:
Joshua D. Baker

14. TITLE:
Director

15. DATE SUBMITTED:
June 14, 2019

16. RETURN TO:
South Carolina Department of Health and Human Services
Post Office Box 8206
Columbia, SC 29202-8206

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 06/28/19

18. DATE APPROVED: 08/28/19

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
04/01/19

20. SIGNATURE OF REGIONAL OFFICIAL:
/s/

21. TYPED NAME:
Kristin Fan

22. TITLE: Director, FMG

23. REMARKS:

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 April 1, 2019, 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 2016 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 April 1, 2019 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 midpoint of the FFY 2018 payment period, the agency will employ the use of the midpoint to midpoint methodology and the use of the first quarter 2018 Global Insight Indexes - 2014 Based CMS Skilled Nursing Home Market Basket Index.

Next, to account for previous South Carolina legislatively funded direct care worker salary increases provided during the July 1, 2017 through June 30, 2018 and July 1, 2018 through June 30, 2019 state appropriation processes, the Medicaid Agency will provide for an additional wage increase factor to be applied against the April 1, 2019 baseline ICF/IID per diem rates described above. In order to determine the direct care worker wage increase factors, the Medicaid Agency accumulated the total amount of direct care worker wage increases associated with each class of ICF/IID facility (i.e. community and institutional) for each legislative period and divided these amounts by the sum of the projected FFY 2018 annual allowable Medicaid costs for each class of ICF/IID facilities. The projected FFY 2018 annual allowable Medicaid costs for each facility was determined by taking the April 1, 2019 baseline ICF/IID per diem rate and multiplying by SFY 2016 Medicaid incurred patient days prior to the application of the wage increase factors. Finally, to determine the final rate for each ICF/IID facility, the wage increase factors of 7.31% for community ICF/IIDs and 9.48% for the institutional ICF/IIDs were applied to the April 1, 2019 baseline ICF/IID per diem rates.

In order to determine the statewide per diem ICF/IID rates (institutional rate or community rate) effective April 1, 2019, the Medicaid Agency will employ the following process:

(1) First, the ICF/IIDs are separated by class (institutional or community). The April 1, 2019 per diem 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.