Table of Contents

State/Territory Name: South Carolina

State Plan Amendment (SPA) #: 19-0010

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 S2-26-12
Baltimore, Maryland 21244-1850

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Financial Management Group

November 4, 2019

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

RE: State Plan Amendment (SPA) 19-0010

Dear Mr. Baker:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number 19-0010. This amendment proposes to (1) rebase rates on the most recent cost report data; (2) require NFs to report costs associated with the operation of Medicaid certified beds only; (3) update the cost center standards based on the most recent cost reports; (4) apply a 2.7% inflation factor in the calculation of the payment rates; (5) revise the calculation of rates for NEMT; (6) replace the current modified FRV system with a updated FRV for capital related expenses; and (7) reimburse impacted NFs for Medicaid's share of Hurricane Florence related evacuation costs due to mandatory evacuation.

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 October 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
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: **19-0010**

2. STATE: SC

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

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
October 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 (Part 447.250)

7. FEDERAL BUDGET IMPACT ($37.0 Million x 70.70%)
a. FFY 2020 $26.2 Million
b. FFY 2021 $Rates to be Rebased

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

Attachment 4.19-D pages, 1, 2, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 26a, 26b, 26c, 26d (*new page*), 28, 28a, 28b, 28c *(new page)*

Removing pages 16a, 16b, 17a and 18a from Attachment 4.19-D due to language shift

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*

Attachment 4.19-D pages, 1, 2, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 26a, 26b, 26c, 28, 28a, 28b,

10. SUBJECT OF AMENDMENT

Nursing Facility Rate Update Effective October 1, 2019 and New Cost of Capital Reimbursement System Effective October 1, 2019

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
13. /s/

13. TYPED NAME
Joshua D. Baker

14. TITLE
Director

15. DATE SUBMITTED
August 15, 2019

16. RETURN TO

South Carolina Department of Health and Human Services
Post Office Box 8206
Columbia, South Carolina 29202-8206

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED 8/16/19

18. DATE APPROVED
11/4/19

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL
10/1/19

20. SIGNATURE OF REGIONAL OFFICIAL
/s/

21. TYPED NAME Kristin Fan

22. TITLE Director, FMG

23. REMARKS

FORM CMS-179 (07/92)

Instructions on Back

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, 2018, 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) excel workbook 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, non-certified Medicaid beds of a facility which participates in the Medicaid (XIX) Program.

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. Failure to submit timely cost reports may result in a percent penalty fee. 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, 2018, nursing facilities will be required to submit their financial and statistical report using the SENIORS excel workbook software. 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.

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 Reimbursement - Fair Rental Value (FRV) Payment System

Effective for dates of service beginning on or after October 1, 2019, the Medicaid Agency will reimburse South Carolina Medicaid contracting nursing facilities (NFs) for capital costs using a Fair Rental Value (FRV) methodology. The payment made under this methodology shall be the only payment made to reimburse providers for building and equipment in lieu of depreciation, interest expense, and lease costs. The only depreciation expense that will continue to be allowed relates to home office building and equipment expense as well as specialty vehicle depreciation expense as outlined in Attachment 4.19-D of the South Carolina Medicaid State Plan. Home office lease expense between unrelated parties will be considered to be allowed as an administrative expense.

(1) FRV Rate Year – Each NF shall receive a new prospective capital per diem rate effective October 1st of each year. The capital per diem rate shall be facility specific and determined each year using the data available from the Capital Data Surveys corresponding to the base year cost report period (i.e. FYE September 30th) used to establish the October 1st payment rates each year. Capital Data Surveys will be submitted annually in conjunction with the annual filing of the SC Medicaid Nursing Facility cost reports. FRV data elements that are not provider specific, including those published by RSMeans Construction Cost Data publication and the rental value rate as determined by the rolling three year average of the three most recently completed calendar years of 10 Year US Treasury Bond interest

rates, shall be determined annually and effective October 1st of each year.

(2) Calculation of FRV Capital Per Diem Rate – The new value construction cost per square foot shall be $256.61 prior to the Location Factor adjustment. After the application of the Location Factor adjustment, the adjusted new value construction cost per square foot shall be $215.55. For the FRV Capital Per Diem rate effective October 1, 2019 and annually thereafter, the adjusted new construction cost of $215.55 per square foot will be trended forward based on the historical cost index factor each October 1st as published annually in the RSMeans Construction Cost Data publication (October 1st, current year divided by October 1st, previous year). The standard square footage minimum and maximums per age group per bed, the $7,000 addition per Medicaid certified bed for equipment, and the 7.50% land value to be added to the fixed capital replacement was established in partnership with the state's nursing facility industry. The FRV Capital Per Diem rate is calculated as follows:

a) First, determine the square footage that will be used in the computation. The square footage that will be used will be the greater of the actual measured gross square footage or the square footage determined by multiplying the number of Medicaid certified beds by the minimum square footage amount per room of 275. However in no event can the square footage used in the payment calculation exceed the maximum square footage ceiling amount per age group multiplied by the number of Medicaid certified beds.

b) Next, to determine the New Building Value Cost, first multiply the square footage determined in step a) above by the January 1, 2018 new value construction cost per square foot of $256.61. To account for the Location Factor of each NF, apply the location factor as provided in the 2018 RSMeans Construction Cost Data publication against the amount calculated above. Location Factors are determined by the state in which the NF is located and the first three digits of the NF's zip code. The Location Factors will be updated annually based upon the base year cost reporting period FYE date.

c) Next, to determine the Moveable Equipment Replacement Value, multiply the number of Medicaid certified beds for each NF by $7,000. Add this calculated amount to the New Building Value Cost as determined in step b) above to arrive at the Building and Equipment Replacement Value for each NF.

d) Next, to adjust for accumulated building and equipment depreciation expense, multiply the Fair Rental Value Age of each NF by an annual 2.00% depreciation rate. Then reduce the Building and Equipment Replacement Value determined in c) above by the calculated accumulated depreciation expense. The Fair Rental Value Age represents the weighted average age of the NF. Bed additions, replacements, and renovations may lower the weighted age of the NF. The maximum calculated age of a NF shall be 30 years; therefore NFs shall not be depreciated to an amount less than 40% (100 % minus (2.0% * 30 years)) of the Building and Equipment Replacement Value. There will be no recapture of depreciation in the event of a sale.

e) Next, to determine the Land Value of each NF, multiply the New Building Value Cost as described in step b) above by 7.50%.

f) Next, to determine the preliminary annual Fair Rental Gross amount of each NF, determine the Building, Equipment, and Land Depreciation Value by adding the amounts determined in steps d) and e) above. Multiply the summed amount by the rental factor of 7.50% to arrive at the Fair Rental Gross amount for each NF. The rental factor rate is based upon the rolling three year average of the yield of the three most recently completed calendar years of 10 Year US Treasury Bond (monthly frequency) interest rates, plus a risk factor of 3.00% with an imposed floor of 7.50% and a ceiling of 9.50%. The rental factor shall be determined annually and become effective October 1st of each year.

g) Next, 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 Fair Rental Gross amount of the nursing facility, plus working capital and specialty vehicle interest, in lieu of actual interest expense.

h) To determine the final Fair Rental Value Gross amount for each NF two steps must occur. First, the preliminary annual Fair Rental Gross amount as determined in step f) above must be reduced by any qualifying income offset(s) or rental revenue offset(s). Next, this reduced amount will be divided by the

greater of actual incurred total patient days or total patient days at 90.00% occupancy to arrive at a FRV Capital Per Diem rate. To account for vent unit and complex care patient days which are reimbursed under a separate Medicaid payment methodology, the FRV Capital Per Diem rate is multiplied by total incurred patient days (less complex care and vent days) to arrive at the final Fair Rental Value Gross amount to be used for Medicaid rate setting purposes.

(3) The initial age of each NF used in the FRV calculation was determined from the fiscal year ending September 30, 2018 Capital Data Survey, using each NF's year of construction. The age may be reduced for replacements, renovations and/or additions which are recorded on the Capital Data Survey to be filed annually with the SC Medicaid Nursing Facility cost report. The age of the NF will be further adjusted each October 1st to make the NF one year older, up to the maximum of 30 years, and to reduce the age for those NFs that have completed and placed into service major renovation(s) or bed additions. If new beds are added, the new beds will be averaged in with the age of the original beds and the weighted average age for all beds will be used as the NF's age. If a NF performed a major renovation/replacement project (defined as a project with capitalized cost equal to or greater than $500 per Medicaid certified bed), the cost of the renovation project completed as of September 30th will be used to determine the weighted average age of all beds for the NF. To compute the weighted average of the beds, determine a weighted average using the number of beds in the age group (value) as the weight. First, multiply each value by its weight. Second, add up the products of age multiplied by weight to get the total value. Third, add the weights together to get the total weight. Fourth, divide the total value by the total weights. The equivalent number of new beds from a renovation project will be determined by dividing the cost of the renovation/replacement project by the accumulated depreciation per bed of the NF's existing beds immediately before the renovation project.

(4) In order to promote and ensure that the new capital funds are being used to update the capital assets (i.e. land, building, and equipment) of SC Medicaid contracting nursing facilities, the Medicaid Agency will employ the following compliance review:

i. Beginning Date of New Policy – October 1, 2019 using capitalized assets purchased prior to October 1, 2018.

ii. Annual Spending Test – There will be an annual spending test to determine if a provider spends the required amount on capital purchases to get credit the following year under the new FRV calculation. The threshold is $500 per Medicaid certified bed. For example, a 100-bed Medicaid certified facility must spend $50,000 (100 beds x $500) each fiscal year (i.e. October 1st – September 30th) for capital purchases to be recognized as an increase to the FRV calculation the following year.

(1) If a facility is undergoing a renovation under a signed construction contract within the compliance measurement in determining compliance with the period, the cost of the project per the construction contract can be included in determining compliance with the expenditure threshold.

(2) Compliance with the $500 per bed threshold is determined based upon the cost of assets capitalized during the compliance measurement period utilizing the facility's current capitalization policies. A facility cannot change those policies for purposes of meeting the expenditure threshold.

(3) If a facility's actual capitalized expenditures are more than quadruple the threshold for the measurement period, the facility is exempt from the expenditure requirement for the subsequent measurement period.

iii. Penalty for Non-Compliance with Spending Test – In the event a nursing facility's age is greater than five years and they do not spend the annual threshold amount as explained above, there will be a ten percent (10%) penalty applied to the capital per diem in

effect prior to the penalty rate period that will be imposed on the next Medicaid rate cycle. This test must be met at least once over a two year period beginning with the October 1, 2022 Medicaid rate cycle (which will be based upon capital spending incurred during the October 1, 2019 thru September 30, 2021 cost reporting period).

iv. Medicaid Rate Years Beginning October 1, 2020 and October 1, 2021 – The penalty for non-compliance of the annual spending test will not be in effect during these two years.

v. Penalty Exemption for Total New Facility Construction or Total Replacement Facility Construction – A newly constructed building or total replacement facility will not be subject to the non-compliance spending test for the first five years of operation.

vi. Verification by DHHS of Annual Capital Spending - In order to document compliance with FRV spending requirements and support capital related costs claimed on the Medicaid Cost Report each year, facilities will be required to submit invoices/documentation to DHHS when filing their cost reports. These invoices will be reviewed and approved by the agency during the rate setting process.

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 October 1, 2019, 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: 10/01/17 through 09/30/18 DATE EFF. 10/01/19

		MAXIMUM BED DAYS:			0
PATIENT DAYS USED:	0	PATIENT DAYS INCURRED:			0
TOTAL PROVIDER BEDS:	0	ACTUAL OCCUPANCY %:		0.00%	
% SKILLED	0.000	PATIENT DAYS @		90.00%	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	2.70%				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 CAP ON COST/PROFIT INCENTIVES				$1.75	0.00
SUBTOTAL					0.00
NON-EMERGENCY MEDICAL TRANSPORTATION (NEMT) ADD-ON					0.00
BUDGET NEUTRALITY ADJUSTMENT		0.0000%			0.00
REIMBURSEMENT RATE					0.00

SC 19-0010
EFFECTIVE DATE: 10/01/19
RO APPROVED: 11/04/2019
SUPERSEDES: MA 05-008

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 (365 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 12) 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 per diem 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 2019 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 2019.

   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 2020 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 2020.

   c. The percent change in the total proxy index during the third quarter of 2019 (as calculated in step a), to the total proxy index in the third quarter of 2020 (as calculated in step b), was 2.70%. Effective October 1, 2019 the inflation factor used was 2.70%.

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. Effective for services provided on or after October 1, 2019, the Medicaid Agency will determine the facility specific Non-Emergency Medical Transportation (NEMT) Add-On as follows:

- For nursing facilities that were not capped by the NEMT transport trip criteria developed by the agency to adjust for significant acuity and utilization shifts observed in the type of NEMT transports among some of the participants residing in the nursing facility and employed in the determination of the October 1, 2018 NEMT add-ons, each facility's October 1, 2019 NEMT add-on will be determined based upon nine months of allowable Medicaid reimbursable NEMT costs incurred from January 1, 2018 through September 30, 2018 divided by the number of incurred and paid January 1, 2018 through September 30, 2018 Medicaid patient days obtained from the agency's SAS reporting system.

- For nursing facilities that were capped by the NEMT transport trip criteria developed by the agency to adjust for significant acuity and utilization shifts observed in the type of NEMT transports among some of the participants residing in the nursing facility and employed in the determination of the October 1, 2018 NEMT add-ons, each facility's October 1, 2019 NEMT add-on will be determined based upon the lower of the NEMT add-on determined October 1, 2018 or nine months of allowable Medicaid reimbursable NEMT costs incurred from January 1, 2018 through September 30, 2018 divided by the number of incurred and paid January 1, 2018 through September 30, 2018 Medicaid patient days obtained from the agency's SAS reporting system.

11. The Medicaid reimbursement rate will be the total of costs accumulated in step 5, inflation, cost of capital, cost incentive/profit, and NEMT Add-On per diem.

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^{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 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^{st}) day of the seventh (7^{th}) 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 13, Paragraph B-1 (e) for the time periods) as reflected on the SCDHHS SAS 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 SAS 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. Also nursing facilities that previously received Medicaid reimbursement which included the costs of non-certified Medicaid beds that now certify all or a portion of these beds will not be entitled to receive a new rate based upon the submission of a budgeted cost report if the Medicaid certified bed capacity increases by more than fifty percent.

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 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^{st}) day of the seventh (7^{th}) 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 13, Paragraph B-1 (e) for the time periods) as reflected on the SCDHHS SAS 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 the Medicaid Agency's 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.

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 recently filed FYE Medicare nursing facility cost report serves as the base year cost report to be used for Medicaid UPL demonstrations. In order to determine the Medicare allowable cost per patient day (i.e. upper payment limit), the SCDHHS will:

(1) Access the most recent and available CMS cost based UPL template for SC Medicaid UPL demonstration purposes.

(2) Gather each nursing facility's Medicare Routine Cost Per Diem from worksheet D-1, Part I, Column 1, Line 16.

(3) Determine and calculate the adjustments that would impact the Medicare Routine Cost Per Diem. This adjustment reflects the per diem costs of the ancillary services which are covered by the SC Medicaid nursing facility per diem rate which includes, but is not limited to, PT, OT, ST, Medical Supplies, Specialty Beds, and etc. The covered ancillary service costs are accumulated by each nursing facility and divided by total incurred patient days as reported on worksheet S-3, Part I, Column 7, Line 1 to arrive at the covered SC Medicaid ancillary per diem adjustment.

(4) To determine the Total Medicare Cost Per Diem, add the Medicare Routine Cost Per Diem in step (2) above to the covered SC Medicaid ancillary per diem adjustment as reflected in step (3) above to arrive at the Total Medicare Cost Per Diem.

(5) To trend the Total Medicare Cost Per Diem to the UPL demonstration period, the Medicaid Agency will employ 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.

(6) Gather each nursing facility's Medicaid per diem rate that is in effect during the Medicaid UPL demonstration period.

(7) In order to adjust for items which are paid outside of the Medicaid per diem rates but have been included as an allowable cost in the determination of the Medicare Routine Cost Per Diems as described in step (2) above, a Medicaid rate per diem adjustment will be determined. Costs relating to CNA training and testing, Hurricane Florence evacuation costs, and professional liability claims will be accumulated for each individual nursing facility and then be divided by the number of total patient days used to determine the Medicaid per diem rate as described in (6) above.

(8) To determine the Total Adjusted Medicaid per diem rate, add the Medicaid Per Diem in step (6) above to the SC Medicaid rate per diem adjustment as reflected in step (7) above.

(9) Medicaid paid days (excluding NF days paid for recipients while under the Hospice Benefit) based upon the most recently completed state fiscal year are applied to the Total Adjusted Medicaid per diem rate as defined in (8) above and the Total Adjusted Medicare Cost Per Diem as described in step (4) above to arrive at the annual Medicaid payments for each provider as well as the annual Total Adjusted Medicare Cost expenditures for each provider.

(10) The annual Total Adjusted Medicare Cost expenditures and the annual Medicaid rate expenditures for all providers within the class are summed to determine the aggregate payments for each class.

(11) The Medicaid UPL compliance check is determined by comparing the aggregate amounts as determined in (9) above to ensure that Total Adjusted Medicare Cost expenditures are equal to or greater than Medicaid rate expenditures. In the event that aggregate Medicaid rate expenditures exceed aggregate Total Adjusted Medicare Cost expenditures, the Medicaid rate for each facility will be limited to the Total Medicare Cost Per Diem as determined in (4) above.

Due to the mandatory evacuation ordered by Governor McMaster of South Carolina in regards to Hurricane Florence, the following nursing facilities may receive a singular private nursing facility UPL payment 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. Nursing facilities that may qualify for this payment include those located within the specified evacuation zones of each of the following coastal areas - Northern South Carolina Coast (Horry County and Georgetown County Evacuation Zones A, B, and C); Central South Carolina Coast (Charleston County - Evacuation Zones A, B, and C; Dorchester County - Evacuation Zones D, E, and F; Berkeley County - Evacuation Zones B, G, H, and I); Southern Coast (Colleton County – Evacuation Zones A and B; Beaufort County – Evacuation Zone A; Jasper County – Evacuation Zones A and B):

Bayview Manor, Life Care Center of Hilton Head, NHC of Bluffton, Heartland Charleston at Hanahan, Lake Moultrie Nursing Center, PruittHealth – Moncks Corner, Johns Island Rehab. & Health Care, Life Care Center of Charleston, Mt. Pleasant Manor, Riverside Health and Rehab., Sandpiper Rehab. & Nursing, West Ashley Rehab & Nursing Center, White Oak Manor – Charleston, PruittHealth – Walterboro, Hallmark Healthcare Center, Oakbrook Health & Rehab., St. George Healthcare Center, Blue Ridge in Georgetown, NHC Garden City, Prince George Healthcare, Compass Post Acute Rehab., Conway Manor, Grand Strand Rehab. & Nursing, Loris Rehab. & Nursing Center, and Ridgeland Nursing Center.

The sum of the private UPL payments will not exceed the upper payment limit calculated under the FFY 2020 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 1st, 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.

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 SAS 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 SAS.

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 most recently filed State Medicaid cost report serves as the base year cost report to be used for Medicaid UPL demonstrations. 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 State Medicaid Regional ICF/IID cost reports. 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 for UPL demonstration purposes. Total patient days are derived from the individual worksheet summaries provided within each State Medicaid Regional ICF/IID cost report.

(2) Next, the Medicaid ICF/IID per diem cost as determined in step (1) above for each facility is then trended. The Medicaid Agency will employ the use of 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 UPL demonstration period.

(3) Next, in order to adjust the trended ICF/IID cost per diems as determined in step (2) above to include the cost impact of the state fiscal year end June 30, 2018 legislatively directed and funded direct care worker salary increases, the Medicaid Agency will further trend the per diems by 3.51% for Community ICF/IIDs and by 4.47% for Institutional ICF/IIDs. These percentages were determined by taking the aggregate cost impact associated with the direct care worker salary increase of each class of ICF/IIDs and dividing these amounts by the aggregate total costs incurred by each class of ICF/IIDs using the most recently filed cost reports. To determine trended Medicaid ICF/IID cost for each ICF/IID for the UPL demonstration period, the individual trended per diem cost rate is multiplied by the base year Medicaid incurred patient days which is obtained via MMIS.

(4) Total annual projected Medicaid ICF/IID revenue of each facility for the UPL demonstration period is determined by averaging the October 1, 2018 and April 1, 2019 Medicaid payment rates of each ICF/IID facility and multiplying the average rate by the facility's base year Medicaid incurred patient days which is obtained via MMIS.

(5) The Medicaid UPL compliance check is determined for this class by comparing the aggregate amounts as determined in step (3) above to ensure that projected Medicaid ICF/IID cost is equal to or greater than projected Medicaid ICF/IID rate expenditures in step (4). 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 (3) above.

V. State Owned Governmental Nursing Facility Service Providers

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

The most recently filed FYE Medicare nursing facility cost report serves as the base year cost report to be used for Medicaid UPL demonstrations. In order to determine the Medicare allowable cost per patient day (i.e. upper payment limit), the SCDHHS will:

(1) Access the most recent and available CMS cost based UPL template for SC Medicaid UPL demonstration purposes.

(2) Gather each nursing facility's Medicare Routine Cost Per Diem from worksheet D-1, Part I, Column 1, Line 16.

(3) Determine and calculate the adjustments that would impact the Medicare Routine Cost Per Diem. This adjustment reflects the per diem costs of the ancillary services which are covered by the SC Medicaid nursing facility per diem rate which includes, but is not limited to, PT, OT, ST, Medical Supplies, Specialty Beds, and etc. The covered ancillary service costs are accumulated by each nursing facility and divided by total incurred patient days as reported on worksheet S-3, Part I, Column 7, Line 1 to arrive at the covered SC Medicaid ancillary per diem adjustment.

(4) To determine the Total Medicare Cost Per Diem, add the Medicare Routine Cost Per Diem in step (2) above to the covered SC Medicaid ancillary per diem adjustment as reflected in step (3) above to arrive at the Total Medicare Cost Per Diem.

(5) To trend the Total Medicare Cost Per Diem to the UPL demonstration period, the Medicaid Agency will employ 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.

(6) Gather each nursing facility's Medicaid per diem rate that is in effect during the Medicaid UPL demonstration period.

(7) In order to adjust for items which are paid outside of the Medicaid per diem rates but have been included as an allowable cost in the determination of the Medicare Routine Cost Per Diems as described in step (2) above, a Medicaid rate per diem adjustment will be determined. Costs relating to CNA training and testing, Hurricane Florence evacuation costs, and professional liability claims will be accumulated for each individual nursing facility and then be divided by the number of total patient days used to determine the Medicaid per diem rate as described in (6) above.

(8) To determine the Total Adjusted Medicaid per diem rate, add the Medicaid Per Diem in step (6) above to the SC Medicaid rate per diem adjustment as reflected in step (7) above.

(9) Medicaid paid days (excluding NF days paid for recipients while under the Hospice Benefit) based upon the most recently completed state fiscal year are applied to the Total Adjusted Medicaid per diem rate as defined in (8) above and the Total Adjusted Medicare Cost Per Diem as

described in step (4) above to arrive at the annual Medicaid payments for each provider as

(10) well as the annual Total Adjusted Medicare Cost expenditures for each provider.

(11) The annual Total Adjusted Medicare Cost expenditures and the annual Medicaid rate expenditures for all providers within the class are summed to determine the aggregate payments for each class.

(12) The Medicaid UPL compliance check is determined by comparing the aggregate amounts as determined in (9) above to ensure that Total Adjusted Medicare Cost expenditures are equal to or greater than Medicaid rate expenditures. In the event that aggregate Medicaid rate expenditures exceed aggregate Total Adjusted Medicare Cost expenditures, the Medicaid rate for each facility will be limited to the Total Medicare Cost Per Diem as determined in (4) 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.