Table of Contents

State/Territory Name: South Carolina

State Plan Amendment (SPA) #: 22-0015

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 S3-14-28
Baltimore, Maryland 21244-1850

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

Financial Management Group

November 9, 2022

Robert M. Kerr
Director, Department of Health & Human Services
Post Office Box 8206
1801 Main Street
Columbia, SC 29202-8206

Reference: State Plan Amendment (SPA) SC-22-0015

Dear Mr. Kerr:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State Plan submitted under transmittal number (TN) 22-0015. This State Plan Amendment (SPA) updates nursing facility payment rates to base year September 30, 2020, cost reports and includes an annual trend factor. The amendment also reduces the minimum occupancy factor used to determine individual Medicaid reimbursement rates and increases the cost center standards for rate setting purposes. The SPA allows adjustment to the skilled level used in establishing each facility's October 1, 2021 rates if it increased based upon state fiscal year 2022 Medicaid paid days; for such a facility, the adjustment will be updated for rate setting purposes effective October 1, 2022. The SPA waives the cost of capital spending requirement for rates effective October 1, 2022, but specifies that per bed spending requirements must be met during the 2022-23 cost reporting period for rates effective October 2024. The SPA updates the "Lost COVID Occupancy" payment methodology, beginning a phase-out effective October 2022. It also applies a two percent (2%) General Services reimbursable cost add-on to each nursing facility's rate to account for significant increases in nursing, CNA, and restorative salaries.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), and 1903(a) of the Social Security Act and the implementing federal regulations at 42 CFR 447 Subpart C.

This is to inform you that Medicaid State Plan Amendment SC-22-0015 is approved, effective October 1, 2022. The CMS-179 and the plan pages are attached.

If you have any additional questions or need further assistance, please contact James Francis at 857-357-6378 or james.francis@cms.hhs.gov.

Sincerely,

[redacted]

Director

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: 22-0015

2. STATE: SC

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

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
October 1, 2022

5. FEDERAL STATUTE/REGULATION CITATION
42 CFR Subpart C (Part 447.250)

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2023 $ ~~15,104,000~~ 20,100,000
b. FFY 2024 $ ~~15,104,000~~ 20,100,000

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

Attachment 4.19-D, pages 4, 8, 9, 11, 12, 13, 14, 15, 17, 26b, 27, 28a, 28b, ~~30b.~~ 30b.1, 30b.2, 41

Page 12a is being deleted from Section 4.19-D

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

Attachment 4.19-D, pages 4, 8, 9, 11, 12, 13, 14, 15, 17, 26b, 27, 28a, 28b, ~~30b.~~ 30b.1, 30b.2, 41

9. SUBJECT OF AMENDMENT

Updating nursing facility payment rates effective October 1, 2022 as well as the "Lost COVID Occupancy" payment methodology.

10. 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:

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME
Robert M. Kerr

13. TITLE
Director

14. DATE SUBMITTED
August 12, 2022

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

FOR CMS USE ONLY

16. DATE RECEIVED
August 12, 2022

17. DATE APPROVED
November 9, 2022

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
October 1, 2022

19. SIGNATURE OF APPROVING OFFICIAL
[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
Rory Howe

21. TITLE OF APPROVING OFFICIAL
Director, Financial Management Group

22. REMARKS

10/7/22: South Carolina authorized pen-and-ink changes to CMS form 179 to remove page 30b of Attachment 4.19-D from blocks 7 and 8. (JGF)

10/7/22: South Carolina authorized pen-and-ink changes to the amounts in block 6 (a and b) on the CMS Form 179 from 15,104,000 to 20,100,000 for both FFY 2023 and FFY 2024. (JGF)

Instructions on Back

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.

However, for the rate period October 1, 2022 thru September 30, 2023 the prospective capital per diem rate has been frozen at the October 1, 2021 per diem rate amount.

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.

(4) 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.

iii. Penalty for Non-Compliance with Spending Test
In the event a nursing facility does not spend the annual threshold amount as described 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. For rates effective October 1, 2022 thru September 30, 2024, the spending requirement is being waived due to COVID-19 access issues. Therefore effective for the October 1, 2024 Medicaid rate period, the spending requirement will be based on the October 1, 2022 thru September 30, 2023 cost reporting period.

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. 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. The only nursing facilities that will be subject to a final audit applicable to the October 1, 2022 thru September 30, 2023 (FFY 2023) rate period will be those nursing facilities whose October 1, 2021 Medicaid rate was limited to its January 1, 2021 Medicaid rate due to the nursing facility receiving Paycheck Protection Program funds during its fiscal year end 2020 cost reporting period. All nursing facilities will be subject to the lower of cost or charges test during this rate period.

Minimum occupancy levels of 85% are currently being utilized for Medicaid rate setting purposes. For clarification purposes, a nursing facility wing that is 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.

PROVIDER NAME: 0
PROVIDER NUMBER: 0
REPORTING PERIOD: 10/01/19 through 09/30/20 DATE EFF. 10/1/2022

		MAXIMUM BED DAYS:(less Complex Care)		0
PATIENT DAYS USED:	0	PATIENT DAYS INCURRED:		0
TOTAL PROVIDER BEDS:	0	ACTUAL OCCUPANCY %:	0.00%	
% Skilled	0.000	PATIENT DAYS @	0.00%	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 6.81% (1.035*1.032=1.0681)				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
GENERAL SERVICES REIMBURSEMENT ADD-ON @ 2%				0.00
REIMBURSEMENT RATE				0.00

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

0 Through 60 Beds
61 Through 99 Beds
100 Plus Beds

B. General Services cost center standards will be computed using private and non-state owned governmental free standing and hospital based nursing facilities. All other cost center standards will be computed using private for profit free standing nursing facilities.

A BRIEF DESCRIPTION ON THE CALCULATION OF ALL THE STANDARDS IS AS FOLLOWS:

1. General Services:

a. Accumulate all allowable cost for the General Services cost center (Nursing & Restorative) for all facilities in each bed size.

b. Determine total patient days by multiplying total beds for all facilities in each group by (366 x 90%).

c. Calculate the mean cost per patient day by dividing total cost in (a) by total patient days in (b).

d. Calculate the standard by multiplying the mean by 110%.

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, 2021 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 October 1, 2022, the percent skilled used in establishing each nursing facility's October 1, 2021 Medicaid reimbursement rate will remain the same unless the percent skilled increased based upon state fiscal year (SFY) 2022 Medicaid paid days. In the event that a nursing facility's percent skilled increased based upon SFY 2022 Medicaid paid days, the percent skilled will be updated for Medicaid rate setting purposes effective October 1, 2022. 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 110%.

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 total patient days as determined under section III A of Attachment 4.19-D.

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 2022 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 2022.

   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 2023 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 2023.

   c. The percent change in the total proxy index during the third quarter of 2022 (as calculated in step a), to the total proxy index in the third quarter of 2023 (as calculated in step b), was 3.20%. To account for another year of inflation to apply to the base year September 30, 2020 cost reporting period, the annual trend factor increased from 3.5% effective October 1, 2021 to 6.81% ((1.035 x 1.032)-1.000) effective October 1, 2022.

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, 2022 NEMT add-on will be determined based upon twelve months of allowable Medicaid reimbursable NEMT costs incurred from October 1, 2019 through September 30, 2020 (FYE Sept. 30, 2020) divided by the number of incurred FYE Sept. 30, 2020 Medicaid days as reported on provider cost reports.

      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, 2022 NEMT add-on will be determined based upon the lower of the NEMT add-on determined October 1, 2018 or twelve months of allowable Medicaid reimbursable NEMT costs incurred from October 1, 2019 through September 30, 2020 (FYE Sept. 30, 2020) divided by the number of incurred FYE Sept. 30, 2020 Medicaid days as reported on provider cost reports.

11. Effective for services provided on or after October 1, 2022, the Medicaid Agency will provide a General Services Reimbursement Add-On of 2% based upon its calculated reimbursable October 1, 2022 General Services costs.

12. For rates effective October 1, 2022, the Medicaid reimbursement rate will be the total of costs accumulated in step 5, inflation, cost of capital, cost incentive/profit, NEMT add-on per diem, and General Services Reimbursement add-on.

(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.

The sum of the private UPL payments will not exceed the upper payment limit calculated under the FFY 2023 private nursing facility UPL demonstration.

(1) Qualifications

In order to qualify for a supplemental payment as an Essential Public Safety Net nursing facility, a nursing facility must meet all of the following criteria:

a) The nursing facility is a non-state owned governmental nursing facility in which the operator of the nursing facility is also the owner of the nursing facility assets;
b) The nursing facility is located in the State of South Carolina;
c) The nursing facility is licensed as a nursing facility by the State of South Carolina and is a current Medicaid provider;

(2) Upper Payment Limit Calculation

The upper payment limit effective for services beginning on and after October 1, 2011 for Essential Public Safety Net nursing facilities will be calculated using the Medicaid frequency distribution of all licensed South Carolina non-state owned governmental nursing facilities which contract with the South Carolina Medicaid Program. This frequency distribution will be determined using the Medicaid MDS assessments completed during the period which corresponds with the quarterly upper payment limit payment period (e.g. October 1 through December 31 and January 1 through March 31, etc.). The results of each nursing facility's Medicaid frequency distribution will then be applied to the total Medicaid patient days (excludes hospice room and board Medicaid patient days and coinsurance days) paid to the nursing facility during each federal fiscal year beginning October 1, 2011 in order to allocate the Medicaid days across the Medicare RUG IV categories. The applicable Medicare rates for the payment year for each RUG category will be applied against the Medicaid days for each RUG category, and then summed, to determine the maximum upper payment limit to be used in the determination of the Essential Public Safety Net nursing facility payments.

Due to Medicare's conversion from the RUGS-IV payment methodology to the Patient Driven Payment Model for Medicare Part A skilled nursing facility services effective October 1, 2019, the Medicaid Agency will increase the October 1, 2018 Medicare RUGS-IV payment rates by the average annual increase in Medicare rates per the FY 2020, 2021, 2022, and 2023 Final Rule. The adjusted Medicare rates will then be used in the calculation of the quarterly Essential Public Safety Net Nursing Facility payments effective for services provided on and after October 1, 2022.

In order to adjust for program differences between the Medicare and Medicaid payment programs, the SCDHHS will calculate Medicaid payments in accordance with Section K(3)(b) of the plan.

(3) Payment Methodology

The South Carolina Department of Health and Human Services will make a supplemental Medicaid payment in addition to the standard nursing facility reimbursement to qualifying Essential Public Safety Net nursing facilities. Such payments will be made quarterly based on Medicaid patient days paid during the payment period. The payment methodology is as follows:

a. The upper payment limit for all licensed South Carolina non-state owned governmental nursing facilities which contract with the South Carolina Medicaid Program will be computed as described under section K(II)(2) above.

(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, 2020 legislatively directed and funded direct care worker salary increase, the Medicaid Agency will further trend the per diems by 3.27% for Community ICF/IIDs and by 4.80% 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 weighting the July 1, 2019 and January 1, 2022 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, 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

R. Medicaid Lost Revenue Payments

The review of current census data relating to all payors continues to reflect the continuing decline in nursing facility occupancy rates. Therefore, in order to assist eligible Medicaid contracting nursing facilities with lost Medicaid patient revenue due to the COVID-19 pandemic, the Medicaid Agency will employ the following payment process effective April 1, 2021.

Qualification Process:

The South Carolina Medicaid contracting nursing facilities that will qualify for the additional payments will be those nursing facilities whose January 1, 2021 total occupancy rate, based upon Medicaid certified beds only, is less than eighty-two percent (82%). Nursing facilities whose January 1, 2021 total occupancy rate is equal to or greater than eighty-two percent (82%) will not be eligible to receive the additional payment. Additionally, any nursing facility whose January 1, 2021 total occupancy rate is greater than their FYE September 30, 2019 total occupancy rate will not be eligible to receive the additional payment.

Individual Payment Calculation Process:

- First, the FYE September 30, 2019 total occupancy rate of each nursing facility is compared to the January 2021 monthly total occupancy rate.

- Next, the difference in the occupancy rates is multiplied by the number of available bed days for a thirty-one (31)-day month to determine the lost total days.

- Next, the lost total days applicable to the thirty-one (31) day month period is multiplied by the FYE September 30, 2019 Medicaid occupancy rate to determine the number of lost Medicaid days.

- Next, the number of lost Medicaid days is multiplied by the nursing facility's January 1, 2021 Medicaid rate to determine the monthly payment amount for each qualifying nursing facility. The quarterly payment calculations will be adjusted to account for the number of days in each month for which the payment represents. The payments will be made via gross adjustments.

- Next, beginning with the July 1, 2021 payment quarter, the total occupancy rate will be reset based upon a more recent SCDHHS selected census month and payments will be adjusted accordingly. This quarterly update methodology (i.e., updated census data) will continue until the end of this payment program.

- Finally, beginning with the October 1, 2022 payment quarter, the above payment methodology will continue to be followed except that the January 1, 2021 Medicaid rate will be reduced from 100% to 85% of the payment rate. In the event that the National Public Health Emergency continues into the beginning of the calendar year 2023 payment quarter, the January 1, 2021 Medicaid payment rate will be reduced from 85% to 60% for that quarter. In the event that the National Public Health Emergency continues into the second quarter of calendar year 2023, the January 1, 2021 Medicaid payment rate will be reduced from 60% to 30% for that quarter and result in the last payment made under this section.

Additional Payment Requirements:

1. Nursing facilities will be required to spend one hundred percent (100%) of the federal funds provided for revenue loss associated with the National Public Health Emergency in order to receive the subject payments.

2. The payment adjustments will end once the National Public Health Emergency is lifted or earlier if total occupancy improves.

3. Nursing facilities will be required to submit monthly census data to the SCDHHS based upon Medicaid certified beds only. This census data will be used to evaluate whether a nursing facility will be eligible to receive or continue to receive payments under this program based upon a moving average two-month period trend rate beginning with the April 2021 census. This information will also be used to reset total occupancy rates used for future quarterly payment purposes.

4. Finally, all interim census data reports used for this payment process will be compared to the FYE September 30, 2022 census report contained within the SC Medicaid Nursing Facility Cost Report to ensure accuracy. This could possibly result in an adjustment to the payment amounts under this program for qualifying nursing facilities in the event that variances exist.

P) COVID-19 Related Costs and Federal Paycheck Protection Program Revenue CARES ACT

All COVID-19 related expenses have been removed from the fiscal year ending September 30, 2020 and June 30, 2020 SC Medicaid cost reports for the determination of the October 1, 2021 payment rates. Therefore, the list of the following costs associated with COVID-19, while not all-inclusive, have been removed: COVID-19 nursing salaries, nursing hero bonuses, nursing isolating pay, other salaries, other hero bonuses, other isolating pay, fringe benefits related nursing and other areas' salaries, nursing consultant, nursing contract labor, minor equipment maintenance, telehealth equipment, electronic devices, nursing supplies, housekeeping supplies, non-capital facility modifications, paper and plastic supplies, billable COVID-19 testing costs, other costs, and non-billable COVID-19 testing costs.

The COVID-19 related costs identified above will be used to justify the four percent (4%) COVID-19 add-on Medicaid reimbursement provided during the March 1, 2020 through September 30, 2020 payment period. The Medicaid Agency will ensure compliance with the guidelines/instructions relating to the reporting requirements of the CARES ACT. The Medicaid Agency will remain flexible in its approach during its 4% COVID-19 add-on reconciliation process to account for any unknown changes that may be made to the CARES ACT reporting requirements that may occur after the time of this state plan submission.