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State/Territory Name: South Carolina

State Plan Amendment (SPA) #: 20-0010

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form/Summary Form (with 179-like data)
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

Financial Management Group

March 23, 2021

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

Reference: TN 20-0010

Dear Mr. Baker:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number 20-0010. This amendment will provide an increase to rates for Medicaid nursing facility providers relating to COVID-19 occupancy issues, COVID-19 employee testing costs, and updated base year cost reports. Effective January 1, 2021, facility specific COVID-19 Add-On services will be eliminated from the reimbursement rate. The state developed a base rate increase in conjunction with various stakeholders that disperses the funds more equitably to providers that need it as opposed to a blanket add-on. The state is also increasing the capital per diem rate effective October 1, 2020.

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-20-0010 is approved effective October 1, 2020. The CMS-179 (HCFA-179) and the plan pages are attached.

If you have any additional questions or need further assistance, please contact Christie Erickson at (410)786-8441 or christie.erickson@cms.hhs.gov.

Sincerely,

[redacted]

Rory Howe
Acting Director

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 20-0010

2. STATE: South Carolina

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

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

4. PROPOSED EFFECTIVE DATE
October 1, 2020; January 1, 2021

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: ($47.0 million x 73.73%)
a. FFY 2021 $34.7 Million
b. FFY 2022 $Rates to be rebased

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-D pages, 5, 11, 11a (New Page), 12, 12a (New Page), 13, 14, 15, 17, 17a, 26a, 26b, 26c, 27, 28a, 28b, 28c, 31, 32, 34

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Attachment 4.19-D pages, 5, 11, 12, 13, 14, 15, 17, 17a, 26a, 26b, 26c, 27, 28a, 28b, 28c, 31, 32, 34

10. SUBJECT OF AMENDMENT:
COVID-19 Nursing Facility Rate Update Effective October 1, 2020 and January 1, 2021.

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. S[redacted]AL:

13. TYPED NAME:
Joshua D. Baker

14. TITLE:
Director

15. DATE SUBMITTED:
December 29, 2020

16. RETURN TO:

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

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED:
3/23/21

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted] For

21. TYPED NAME:

22. TITLE:

23. REMARKS:

FORM HCFA-179 (07-92)

(2) Calculation of FRV Capital Per Diem Rate – The new value construction cost per square foot shall be established at $215.55 prior to the Location Factor adjustment. For the FRV Capital Per Diem rate effective October 1, 2019 and annually thereafter, the 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). Effective October 1, 2020 the adjusted new construction cost per square foot will amount to $222.96. 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. For clarification purposes, nursing facilities are allowed to include the square footage related to other facilities on the campus that are used to provide patient care related services such as kitchen or laundry facilities. However, the square footage of "out buildings" used for storage purposes cannot be included. In the event that a nursing facility fails to provide its required square footage data, the Medicaid Agency will determine the square footage at the minimum square footage allowance per bed along with the use of a thirty (30) year life.

b) Next, to determine the New Building Value Cost, first multiply the square footage determined in step a) above by $222.96. 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.

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.

For rates effective on or after October 1, 2020, the total patient days used in the computation of the nursing facility rates are “COVID-19 occupancy adjusted” to account for the changes in nursing facility occupancy during the COVID-19 event and the use of a minimum occupancy rate of 87.50% (75%*90% plus 25% *80%). The total patient days used for rate setting purposes applied to all rate components except for Capital cost and Non-Emergency Medical Transportation (NEMT) cost. The total patient days used for these two cost categories are described in sections III C 7 and III C 10 of Attachment 4.19-D.

Total patient days are determined using a weighted average occupancy rate as follows – 75% of the total patient days were based upon the FYE September 30, 2019 occupancy rates while the remaining 25% of the total patient days were based upon the May 2020 thru June 2020 occupancy rates. The weighted average occupancy rate of each nursing facility was then applied to maximum bed days available during the FYE 2019 cost reporting period to determine the total patient days used for rate setting purposes prior to being subject to the minimum occupancy adjustment. The total patient days were then compared to minimum occupancy days determined at 87.50% and the greater of the two amounts were used for October 1, 2020 rate setting purposes. Medicaid rates for nursing facilities located in counties where the county occupancy rate is less than 85% based upon the FYE 2019 cost report information will use the following criteria.

- The SCDHHS will waive the 87.50% 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 COVID-19 occupancy adjusted total patient days 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:	10/01/18	through	09/30/19	DATE EFF.	10/1/2020
RATE PERIOD:	10/1/2020	through	09/30/21		

		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

PATIENT DAYS INCURRED REPRESENT 25/75 BLEND OF MAY 2020 AND JUNE 2020 CENSUS DAYS AND FYE SEPTEMBER 30, 2019 CENSUS DAYS, WITH BLENDED MINIMUM OCCUPANCY SET AT 87.5%.

COMPUTATION OF REIMBURSEMENT RATE - PERCENT SKILLED METHODOLOGY

		PROFIT INCENTIVE	TOTAL ALLOW COS	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	2.50%				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
COVID-19 EMPLOYEE TESTING ADD-ON FOR OCT. 1, 2020 THRU DEC. 31, 2020					0.00
REIMBURSEMENT RATE					0.00

PROVIDER NAME:	0				
PROVIDER NUMBER:	0				
REPORTING PERIOD:	10/01/18	through	09/30/19	DATE EFF.	01/01/21
RATE PERIOD:	10/1/2020	through	09/30/21		

	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

PATIENT DAYS INCURRED REPRESENT 25/75 BLEND OF MAY 2020 AND JUNE 2020 CENSUS DAYS AND FYE SEPTEMBER 30, 2019 CENSUS DAYS, WITH BLENDED MINIMUM OCCUPANCY SET AT 87.5%.

COMPUTATION OF REIMBURSEMENT RATE - PERCENT SKILLED METHODOLOGY

		PROFIT INCENTIVE	TOTAL ALLOW COS	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	2.50%				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
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 (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 110% in order to account for COVID-19 occupancy issues.

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 110% in order to account for COVID-19 occupancy issues.

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 2020 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 2020.

   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 2021 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 2021.

   c. The percent change in the total proxy index during the third quarter of 2020 (as calculated in step a), to the total proxy index in the third quarter of 2021 (as calculated in step b), was 2.50%. Effective October 1, 2020 the inflation factor used was 2.50%.

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

11. In its' continuation of providing SC Medicaid contracting nursing facilities with financial assistance related to COVID-19 employee testing costs based upon federal guidelines, the Medicaid Agency will provide for a new COVID-19 add-on effective October 1, 2020. The COVID-19 add-on will be determined based upon FYE 2019 nursing facility adjusted FTEs per the Medicare cost reports, weekly testing of employees (i.e. 52 tests per year) throughout the year, a unit testing cost of $75.00, and the use of COVID-19 adjusted total patient days as defined in section III A of Attachment 4.19-D. This COVID-19 add-on will be subject to cost justification and only overpayments will be recouped. The COVID-19 add-on will only be effective for services incurred from October 1, 2020 thru December 31, 2020. Effective for services incurred on and after January 1, 2021, the COVID-19 add-on will be eliminated and nursing facilities will be required to enter into an arrangement with the Medical University Hospital Authority (MUHA) for employee COVID-19 testing. The SCDHHS will then reimburse the MUHA directly for Medicaid's share of the nursing facility's COVID-19 employee testing costs.

12. For rates effective October 1, 2020, 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 COVID-19 add-on per diem.

13. For rates effective January 1, 2021, 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.

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) To remove the impact of the COVID-19 add-on, gather each nursing facility's January 1, 2021 Medicaid per diem rate as the sole rate used for 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 Dorian 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 Dorian, 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 Zone A); Central South Carolina Coast (Charleston County - Evacuation Zones A, B, and C; Dorchester County - Evacuation Zone D; 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 Zone A :

Bayview Manor, Life Care Center of Hilton Head, NHC of Bluffton, Heartland Charleston at Hanahan, Life Care Center of Charleston, Mt. Pleasant Manor, Riverside Health and Rehab., Sandpiper Rehab. & Nursing, West Ashley Rehab & Nursing Center, White Oak Manor – Charleston, Oakbrook Health & Rehab., Blue Ridge in Georgetown, Prince George Healthcare.

The sum of the private UPL payments will not exceed the upper payment limit calculated under the FFY 2021 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.

(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 and FY 2021 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, 2020.

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, 2018, June 30, 2019, and June 30, 2020 legislatively directed and funded direct care worker salary increases, the Medicaid Agency will further trend the per diems by 11.05% for Community ICF/IIDs and by 14.67% 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 July 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 Dorian 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.

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.

C) Legal Fees

For rates effective October 1, 2006, allowable Medicaid reimbursable costs include reasonable legal fees arising from normal day-to-day business activities related to patient care as defined in HIM-15. Any legal fees recognized as allowable Medicaid costs must be demonstrated to be necessary for the efficient delivery of needed health care services provided by the facility.

Additionally, retainer fees would not be considered an allowable cost.

D) Travel

Patient care related travel will be recognized in accordance with South Carolina state employees per diem and travel regulations. Out-of-state travel will be limited to the 48 states located within the continental United States. Further, such out-of-state travel must be either the reasonable allocable portion of cost for chain facilities with out-of-state offices; or (1) be for the purpose of meeting continuing education requirements and (2) must be to participate in seminars or meetings that are approved for that purpose by the South Carolina Board of Examiners for Nursing Home Administrators. Allowable cost for attendance at out-of-state meetings and seminars will be limited to two trips per year per facility. Also, out-of-state travel does not include travel to counties bordering the State of South Carolina. Effective for July 1, 1990 payment rates, travel to the following states/areas are treated as in-state travel, and thus are not subject to the limits on out-of-state travel: Georgia, North Carolina, Washington D.C., and Baltimore, Maryland.

E) Director Fees

Director fees and costs associated with attending board meetings or other top management responsibilities will not be allowed. However travel to and from the directors meetings will be allowed at the per mile rate for state employees and will be limited to in-state travel.

JOB TITLE	0-60 BEDS MAX ALLOWED ANNUAL SALARY	61-99 BEDS MAX ALLOWED ANNUAL SALARY	100+ BEDS MAX ALLOWED ANNUAL SALARY
DIRECTOR OF NURSING (DON)	$79,326	$83,994	$104,532
RN	$59,998	$60,784	$64,072
LPN	$48,966	$48,966	$51,152
CNA	$24,823	$24,823	$26,520
SOCIAL SERVICES DIRECTOR	$40,671	$42,263	$52,552
SOCIAL SERVICES ASSISTANT	$34,731	$34,731	$40,586
ACTIVITY DIRECTOR	$33,691	$34,561	$37,531
ACTIVITY ASSISTANT	$22,468	$22,913	$25,078
DIETARY SUPERVISOR	$41,265	$45,657	$56,350
DIETARY WORKER	$20,177	$21,385	$24,229
LAUNDRY SUPERVISOR	$29,681	$29,681	$29,681
LAUNDRY WORKER	$17,949	$19,731	$22,022
HOUSEKEEPING SUPERVISOR	$29,321	$35,367	$39,207
HOUSEKEEPING WORKER	$18,733	$19,668	$21,407
MAINTENANCE SUPERVISOR	$39,122	$43,705	$51,788
MAINTENANCE WORKER	$28,578	$28,684	$32,058
ADMINISTRATOR	$91,547	$103,237	$134,213
ASSISTANT ADMINISTRATOR	$66,957	$79,517	$79,517
BOOKKEEPER / BUSINESS MGR	$46,208	$46,208	$48,669
SECRETARY / RECEPTIONIST	$28,981	$29,278	$30,636
MEDICAL RECORDS SECRETARY	$36,916	$36,916	$36,916

Note: State employee pay increase of 2% effective 07/01/19

G) ALLOWABLE COMPENSATION RANGES FOR OWNERS AND/OR THEIR RELATIVES EMPLOYED BY PARENT COMPANIES:

JOB TITLE	% - CEO Compensation	0-60 BEDS	61-99 BEDS	100-257 BEDS	258 + BEDS	
CEO	see nh admin. Guidelines	$91,547	$103,237	$134,213	130%* 100+ admin. Guidelines	$174,476
ASST CEO CONTROLLER CORPORATE SECRETARY CORPORATE TREASURER ATTORNEY	75%	$68,660	$77,428	$100,659		$130,857
ACCOUNTANT BUSINESS MGR PURCHASING AGENT REGIONAL ADMINISTRATOR REGIONAL V-P REGIONAL EXECUTIVE	70%	$64,083	$72,266	$93,949		$122,133
CONSULTANTS: SOCIAL ACTIVITY DIETARY (RD) PHYSICAL THER (RPT) MEDICAL RECORDS (RRA) NURSING (BSRN)	65%	$59,506	$67,104	$87,238		$113,409
SECRETARIES	see nh	$28,981	$29,278	$30,636		$30,636
BOOKKEEPERS	see nh	$46,208	$46,208	$48,669		$48,669
MEDICAL DIRECTOR	90%	$82,392	$92,914	$120,791		157,028
****NOTE: there are no home offices in the 0-60 bed group**						

Note: State employee pay increase of 2% effective 07/01/19.

1. The above are maximum limits of allowable cost for owners and/or relatives who are actually performing these duties 100% of a normal work week. Part-time performance will be computed according to time spent. No individual will have more than one full time equivalent (40 hour per week) job recognized in the Medicaid program.

2. No assistant operating executive will be authorized for a chain with 257 beds or less.