

CHAPTER 126

Department of Health and Human Services

(Statutory Authority: 1976 Code § 44-6-90)

ARTICLE 1 ADMINISTRATION

SUBARTICLE 2 NONDISCRIMINATORY PRACTICES

126-125. General.

The State Health and Human Services Finance Commission shall administer its programs in accordance with Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975, as amended, to the end that no person shall be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination on the basis of race, color, national origin, handicap or age, either directly or through contractual or other arrangement. Any individual who feels he has been subjected to such discrimination may, within one hundred eighty (180) days of the alleged discriminatory act, file a signed written complaint with:

State Health & Human Services Finance Commission
Post Office Box 8206
Columbia, South Carolina 29202

-OR-

S.C. Department of Social Services
Post Office Box 1520
Columbia, South Carolina 29202

-OR-

Local County Department of Social Services
Such complaint will be investigated in accordance with state and federal laws and regulations.

SUBARTICLE 3 APPEALS AND HEARINGS

126-150. Definitions.

- A. Agency—The Department of Health and Human Services and its employees.
- B. Appeal—The formal process of review and adjudication of Agency determinations, which shall be afforded to any person possessing a right to appeal pursuant to statutory, regulatory and/or contractual law; *Provided*, that to the extent that an appellant's appellate rights are in any way limited by contract with the Agency or assigned to the Agency, said contractual provision shall control.
- C. Hearing Officer—Any Agency employee appointed by the Director to make Decisions either affirming or reversing Agency program determinations by setting forth findings of fact and conclusions of law in appeals arising under this regulation.
- D. Person—An individual, partnership, corporation, association, governmental subdivision, or public or private agency or organization.

E. Provider—A person who provides services to individuals under programs administered by the Agency.

HISTORY: Amended by State Register Volume 21, Issue No. 3, eff March 28, 1997.

126–152. Appeal Procedure.

A. An appeal shall be initiated by the filing of a notice of appeal within thirty (30) days of written notice of the Agency action or decision which forms the basis of the appeal. The failure to file the requisite notice of appeal within the thirty (30) day period specified above shall render the Agency action or decision final; *provided*, that should the written notice specify some period to appeal other than thirty (30) days, that period shall apply; *provided*, that the requirement that written notice be given by the Agency shall not be applicable to situations where applicants for Medicaid benefits acquire the right to appeal when the Agency fails to act on the application within the time period specified by federal regulation.

B. The notice of appeal shall be in writing and shall be directed to Appeals and Hearings, Department of Health and Human Services, Post Office Box 8206, Columbia, South Carolina 29202-8206. In appeals by providers, the notice of appeal shall state with specificity the adjustment(s) or disallowance(s) in question, the nature of the Issue(s) in contest, the jurisdictional basis of the appeal and the legal authority upon which the appellant relies.

C. If a notice of appeal does not satisfy the requirements of paragraph (B) above, the Hearing Officer, upon his own motion or by motion by an adverse party, may require a more definite and certain statement.

HISTORY: Amended by State Register Volume 21, Issue No. 3, eff March 28, 1997.

126–154. Hearing Officer.

A Hearing Officer has the authority, among other things to: direct all procedures; issue interlocutory orders; schedule hearings and conferences; preside at formal proceedings; rule on procedural and evidentiary issues; require the submission of briefs and/or proposed findings of fact and conclusions of law; call witnesses and cross-examine any witnesses; recess, continue, and conclude any proceedings; dismiss any appeal for failure to comply with requirements under this Subarticle.

126–156. Prehearing Conferences.

The Hearing Officer, within his discretion, may direct the parties in any appeal to meet prior to a formal hearing for the purpose of narrowing the issues and exploring the possibilities of settlement of matters in contest.

126–158. Hearing Procedures.

A. All parties to an appeal shall have the right to be represented by counsel, call witnesses, submit documentary evidence, cross-examine the witnesses of an adverse party, and make opening and closing statements.

B. Representation in Proceedings. A business entity, an agency, or an organization may elect to be represented by a non-attorney in an administrative hearing with the approval of the presiding hearing officer; non-lawyer persons including Certified Public Accountants, an officer of a corporation, or an owner of an interest in the business entity must present proof of unanimous consent of the owners or officers of the business entity before being allowed to proceed as representatives. Attorneys licensed in other jurisdictions must obtain a Limited Certificate of Admission, or such other leave as required by the South Carolina Supreme Court, before being allowed to proceed as representatives. This regulation in no way limits a person's right to self-representation, or to be represented by an attorney, or to be represented by a non-attorney of his or her own choosing, when such non-attorney representation is allowed by law.

HISTORY: Amended by State Register Volume 28, Issue No. 6, eff June 25, 2004.

SUBARTICLE 4
SAFEGUARDING OF CLIENT INFORMATION

126–170. General.

A. Disclosure of Commission held client information is limited to purposes directly connected to the administration of the Commission's programs and grants.

B. This Subarticle applies to Commission held client information from all programs and grants administered by the Commission and applies to all requests for client information received from outside the agency.

C. In addition to the safeguards provided by this Subarticle the following may apply:

1. Records maintained in connection with any federally assisted alcohol or drug abuse program are subject to special confidentiality standards contained in the Public Health Service Act. The intent is that those Sections (currently, 42 USC §§ 290dd-3 & 290ee-3), however amended or recodified are referenced here as long as they apply.

2. Information received by the Commission from another agency may continue to be protected by the confidentiality statutes or regulations of that agency. In each instance, the receiver of the information should understand what statutes and regulations apply.

HISTORY: Added by State Register Volume 16, Issue No. 6, eff June 26, 1992.

126–171. Protected Information.

Protected information is of two (2) general types which include but are not limited to the following:

A. Information regarding the financial eligibility determination and authorization of payment or benefits:

1. Names and addresses;
2. Social and economic conditions or circumstances;
3. Commission evaluation of personal information such as financial status, citizenship, residence, age, and other demographic characteristics;
4. Information received for verifying income, eligibility, and amount of benefits; and
5. Information received in connection with the identification of a liable third party resource.

B. Medical Information:

1. Medical data, including diagnosis and history of diseases or disabilities;
2. Medical services provided;
3. Medical status, psycho behavioral status, and functional ability;
4. Results of laboratory tests; and
5. Medication records.

HISTORY: Added by State Register Volume 16, Issue No. 6, eff June 26, 1992.

126–172. Purposes Directly Connected to the Administration of the Programs and Grants.

Purposes directly connected to the administration of programs and grants include, but are not limited to:

- A. Establishing eligibility;
- B. Determining the amount of payments or other benefits;
- C. Providing or arranging for services;
- D. Confirming eligibility for billing purposes;
- E. Conducting or assisting in investigations, prosecutions or criminal or civil proceedings related to the administration of programs or grants; and
- F. Conducting research used in program planning and evaluation, provided that the researcher agrees to be bound by the provisions of this Subarticle and any Research Protocol adopted by the Commission.

HISTORY: Added by State Register Volume 16, Issue No. 6, eff June 26, 1992.

126–173. Release of Information.

A. Access to eligibility information is restricted to persons, agencies, and entities which by their own rules or by contract are subject to confidentiality standards which are comparable to those set forth in this Subarticle. In addition, the information released must be subject to the following by agreement or by attaching the NOTICE directly to the information provided:

NOTICE: THIS IS CONFIDENTIAL INFORMATION FROM THE RECORDS OF THE SOUTH CAROLINA STATE HEALTH AND HUMAN SERVICES FINANCE COMMISSION. OUR AUTHORIZATION TO RELEASE THIS INFORMATION TO YOU DOES NOT IMPLY PERMISSION TO FURTHER DISCLOSE THIS INFORMATION EVEN WITHIN YOUR OWN ORGANIZATION/AGENCY. RERELEASE OF THIS INFORMATION SHOULD BE GOVERNED BY YOUR OWN CONFIDENTIALITY STANDARDS, CONTRACTUAL RELATIONSHIPS, AND ANY APPLICABLE STATUTES AND REGULATIONS.

B. Organizations, agencies, and individuals (and their agents, as permitted by program rules) that provide services which are paid for by the Commission, will at times need to verify program eligibility through the Finance Commission or its agents. The Commission and its agents will comply with requests in which the requesting party can furnish information, as specified by the Commission, which uniquely identifies the requesting provider of services and the recipient about which information is sought.

C. With respect to non emergency requests, from any source, for medical information, the Commission must be given the original or a legible photocopy of written permission, executed by the individual or someone authorized to make decisions for the individual before complying. Any information supplied must be accompanied by the NOTICE in A. above.

D. If an emergency exists with respect to medical information, the Commission will notify the individual or the authorized representative immediately after supplying the information. Any information supplied must be accompanied by the NOTICE in A. above.

E. If a court issues a subpoena for agency held information specifically identifying a client, the Commission must either obtain the individual's consent to release the information, or obtain an order, from a competent court, for the release of the information after apprising the court of the existence of these and any other confidentiality rules which apply. Any information supplied must be accompanied by the NOTICE in A. above.

F. The Commission may release information in accordance with data exchange agreements permitted by federal and state statutes or regulations.

G. The Commission may release general information or statistical information such as total expenditures, the number of clients served, and other information which does not fall within the class of information which can be identified with any particular individual.

H. The Commission is required to release protected information to state and federal auditors, performing bona fide audits of the Commission's operations. When the Commission contracts for audits, the contract must bind the auditor to the standards contained in this Subarticle.

HISTORY: Added by State Register Volume 16, Issue No. 6, eff June 26, 1992.

126–174. Distribution of Materials to Recipients and Providers.

A. The agency may not distribute any materials to recipients or providers unless the material has no political implications, provides no commercial advantage to any entity, and is directly related to the administration of programs.

B. The agency may distribute materials that are directly related to the health, welfare and safety of recipients and providers such as announcements of free medical examinations, availability of surplus food, and consumer protection information.

HISTORY: Added by State Register Volume 16, Issue No. 6, eff June 26, 1992.

126–175. Penalties.

A. The Commission may impose sanctions for violations of the provisions of this Subarticle through its progressive disciplinary procedures for Commission personnel.

B. The intent is that violations of this Subarticle may also be subject to penalty provisions in the Commission's statutes.

HISTORY: Added by State Register Volume 16, Issue No. 6, eff June 26, 1992.

**ARTICLE 3
MEDICAID**

**SUBARTICLE 1
SCOPE OF THE PROGRAM**

126-300. General.

A. Clients eligible for Medicaid may obtain medically necessary services from providers enrolled in the program.

B. Medicaid recipients who are residents of South Carolina and referred for medical services outside "South Carolina Medicaid Services Area" must receive prior approval for these services from the state agency administering the Medicaid Program. "South Carolina Medicaid Services Area" is South Carolina and adjacent areas within twenty-five (25) miles of its borders.

C. Co-payment may be required for services as specified in the South Carolina State Plan for Title XIX (Medicaid).

D. Services are subject to limits and procedural requirements described in the South Carolina State Plan for Title XIX (Medicaid), provider manuals, Medicaid Bulletins, and federal directives.

126-301. Services Covered by the Medicaid Program.

A. Categorically eligible:

- (1) Audiology services
- (2) Certified nurse midwifery services
- (3) Community long term care services
- (4) Dental Services
- (5) Durable medical equipment
- (6) Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services
- (7) End stage renal disease services
- (8) Family planning services
- (9) Hospital service
- (10) Laboratory and x-ray services
- (11) Medical transportation services
- (12) Mental health clinic services
- (13) Nursing facility services
- (14) Physician services
- (15) Podiatry services
- (16) Prescribed drugs
- (17) Psychiatric facility services
- (18) Rehabilitative services
- (19) Rural health clinic services
- (20) Speech pathology
- (21) Tubercular facility services
- (22) Vision care

B. Deleted.

C. Individuals eligible for home and community based services are entitled to receive the following:

- (1) All services listed under categorically eligible.
- (2) Community long term care home and community based services.

HISTORY: Amended by State Register Volume 16, Issue No. 2, eff February 28, 1992; State Register Volume 19, Issue No. 3, eff March 24, 1995.

126-302. Audiology Services.

Audiology services are hearing evaluations and hearing aids for recipients through the month they turn twenty-one years of age.

126-303. Certified Nurse Midwifery Services.

Midwifery services are covered when furnished by a certified nurse midwife (CNM) in a clinical practice meeting the education and training requirements set forth in the laws governing nursing in South Carolina pertaining to CNM's.

126-304. Community Long Term Care Home and Community Based Services.

A. Home and community based services may be provided to Medicaid eligible persons eighteen years of age or older, who have been determined by community long term care to require a skilled or intermediate level of care.

B. Types of services:

- (1) Expanded therapies include physiotherapy, occupational therapy and speech therapy provided at home.
- (2) Home delivered meals is the in home provision of at least one meal per day to persons unable to care for their nutritional needs.
- (3) Medical day care is a group of services to restore, maintain and promote health status through the provision of ambulatory health care and health related supportive services in a licensed medical day care center.
- (4) Medical social services are supportive services provided by an individual with no less than a Masters Degree in social work.
- (5) Personal care is the in home provision of the necessary services of support of activities of daily living, home support, medical monitoring, and client transportation services to restore, maintain and promote health status.
- (6) Respite care is the provision of temporary institutional care for eligible clients living at home and cared for by their families or other informal support persons. This service will provide temporary relief for the primary care givers.
- (7) Service management includes assessment and reassessment, level of care of determination, service planning, service coordination, and counseling.

126-305. Dental Care.

Dental Care consists of any covered preventive, surgical, therapeutic and emergency dental service provided by a licensed dentist. Only emergency dental services are available for recipients age twenty-one years and over.

126-306. Durable Medical Equipment.

Durable medical equipment consists of orthotic and prosthetic devices, supplies and durable medical equipment when medically necessary.

126-307. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services are available to eligible Medicaid recipients from birth through the month they turn twenty-one years of age. This program covers initial screening, periodic screening, diagnosis, and treatment. All services included in the Title XIX State Plan are available to those eligible.

126–308. End Stage Renal Disease Services.

End stage renal disease services are available in or out of a hospital or clinic.

126–309. Family Planning Services.

Family planning services are furnished for purposes of enabling such individuals to freely determine the number and spacing of their children. Services are available to minors who are considered to be sexually active.

126–310. Hospital Services.

A. Inpatient hospital services provided by the Medicaid Program are for the care and treatment of illness, injuries or disabilities certified medically necessary by a physician and reviewed for appropriateness of admission, length of stay and ancillary services, by the utilization review mechanism established by the State Health and Human Services Finance Commission.

B. Outpatient hospital services sponsored by the Medicaid Program are ambulatory visits for the care and treatment of illness, injuries and disabilities certified as medically necessary by a physician. This does not include routine dental services. Therapy may be provided on an ambulatory basis as a continuing part of an inpatient stay.

126–311. Laboratory and X-ray Services/Tests.

Laboratory and x-ray services/tests must be ordered by a professional practitioner within the scope of his/her practice with the expectation of making a reasonable medical determination.

126–312. Medical Transportation Services.

Medically necessary transportation services by ambulance, contracted transportation providers and volunteer drivers are available to recipients receiving covered Medicaid service.

126–313. Mental Health Clinic Services.

Mental health clinic services are those services that are provided on an outpatient basis within a community setting meeting the standards as set forth by the South Carolina Department of Mental Health

126–314. Nursing Facility Services.

Medicaid sponsors skilled, intermediate, and intermediate/persons with intellectual disability nursing care services in accordance with the level of care determination established by the utilization review mechanism.

These nursing facility services shall be provided in a facility which contracts with the Medicaid (Title XIX) state agency. Such services shall be provided according to a written plan of care under the direction of a licensed attending physician. The physician shall certify the need for continued nursing facility services consistent with federal requirements.

Code Commissioner's Note

Pursuant to 2011 Act No. 47, §14(B), the Code Commissioner substituted "intellectual disability" for "mental retardation" and "person with intellectual disability" or

"persons with intellectual disability" for "mentally retarded".

126–315. Physicians' Services.

Physicians' services must be medically necessary and furnished by or under the direct supervision of an individual licensed under state law to practice medicine or osteopathy and within the scope of practice of these disciplines.

126–316. Podiatry Services.

Podiatry services are those services that are necessary for the diagnosis and treatment of foot conditions not associated with routine foot care.

126–317. Prescribed Drugs.

Prescribed drugs are drugs prescribed by a licensed practitioner and dispensed by a licensed pharmacist or practitioner according to limitations set forth in the Title XIX State Plan and in provider manuals.

126–318. Psychiatric Facility Services.

Inpatient psychiatric facility services are available for individuals younger than twenty-two years of age and sixty-five years of age and older.

126–319. Rehabilitative Services.

Rehabilitative services are limited to outpatient mental health rehabilitative services meeting standards as determined by the State Health and Human Services Finance Commission and the South Carolina Department of Mental Health.

126–320. Rural Health Clinic Services.

Rural health clinic services are medically necessary services provided by a facility which participates in the Medicare Program and contracts with the Health and Human Services Finance Commission.

126–321. Speech Pathology.

Speech evaluations are provided by authorized providers for Medicaid recipients through the month they turn twenty-one years of age.

126–322. Tubercular Facility Services.

Tubercular facility services are limited to individuals age sixty-five or older in institutions for the treatment of tuberculosis and include only inpatient hospital services.

126–323. Vision Care.

Vision care consists of vision examination and corrective eye-wear to include contact lenses when medically necessary. Only post surgical lenses are available for recipients age twenty-one years and over.

126–335. Hospital Reimbursement.

A. Reimbursement for covered inpatient hospital services shall be by a prospective payment system.

B. Providers may seek a correction to the statistical calculation which establishes the maximum allowable payment rate by requesting in writing a reconsideration of such rate to: Bureau of Health Services, Hospital Reimbursement, State Health and Human Services Finance Commission, Post Office Box 8206, Columbia, South Carolina 29202-8206. If the provider disagrees with the decision of the Department of Hospital Rate Setting, he may appeal the decision in accordance with R.126-150 et seq.

SUBARTICLE 2

ELIGIBILITY FOR THE MEDICAL ASSISTANCE (MEDICAID) PROGRAM

126–350. Definitions.

A. Medicaid is the common name for Title XIX of the Social Security Act.

B. Medicare is the common name for Title XVIII of the Social Security Act.

C. Supplemental Security Income (SSI) is the common name for Title XVI of the Social Security Act. It is administered by the Social Security Administration (SSA).

D. Medical Assistance Only (MAO) is the common name for those programs that provide medical assistance and services to eligible recipients, but which do not provide any cash assistance.

E. Medicaid Cap is the gross monthly income limitation which is established by the South Carolina General Assembly. An individual whose monthly income, before deductions, exceeds this limitation shall not be eligible for MAO.

F. A medical institution is a licensed institution, organized and authorized under State law to provide medical, nursing and convalescent care.

G. Community Long Term Care (CLTC) performs certification of medical necessity and level of long term care for Medicaid applicants and recipients.

H. Recurring Income, also known as patient liability, is the individual's gross income, less certain exclusions as defined by federal regulation, that the individual must apply to the cost of care.

I. Personal Needs Allowance is the amount that is set aside from the individual's income for his personal needs, such as clothing, toiletries and incidentals. The allowance, set by the Title XIX State agency for persons in certified medical facilities, varies according to the category of assistance for which the person qualifies. The appropriate personal needs allowance for each category of assistance is found in the Title XIX State Plan.

J. Vendor Payment is the net payment made by the agency to a medical facility for an individual's cost of care after deducting the individual's recurring income, if any, from the South Carolina Medicaid rate of payment.

K. Categorically Needy means aged, blind, or disabled individual or families and children who are otherwise eligible for Medicaid and who meet the financial eligibility requirements for Aid to Families with Dependent Children (AFDC), SSI, or an optional State supplement, or are considered under section 1619(b) of the Social Security Act to be SSI recipients; or whose categorical eligibility is protected by statute.

L. Federal poverty level means the non-farm poverty level for the appropriate family size as published by the federal Office of Management and Budget (OMB) and revised yearly.

M. Deleted.

HISTORY: Amended by State Register Volume 16, Issue No. 2, eff February 28, 1992; State Register Volume 19, Issue No. 3, eff March 24, 1995.

126-355. Application Procedures.

A. Any individual or family who is determined eligible for financial assistance under the Aid to Families with Dependent Children, Optional State Supplementation, Refugee Assistance, or Supplemental Security Income programs is eligible for Medicaid without filing a separate application.

B. If an individual who has been determined eligible for financial assistance dies before receiving an actual assistance payment, the date of application for financial assistance shall serve as the application for Medicaid. Medicaid coverage is available to the individual for the period of time for which he was determined eligible.

C. All other individuals must file an application for Medicaid benefits with the Department of Social Services.

D. The following time standards shall be used for determinations of eligibility:

(1) Sixty (60) days for applicants who apply for Medicaid on the basis of disability and forty-five (45) days for all other applicants.

(2) These time standards do not apply if unusual circumstances exist (e.g., the agency cannot reach a decision because the applicant or an examining physician delays or fails to take required action) or if there is an administrative or other emergency beyond the agency's control and a determination of eligibility cannot be made within these time standards.

126-360. General Requirements.

A. Medical assistance is available to residents of this State who meet the eligibility requirements of this chapter and who are United States citizens or who are aliens lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law. Residence is determined in accordance with Title XIX of the Social Security Act and the federal regulations promulgated in accordance therewith:

B. Initial Date of Entitlement for Medicaid.

(1) The initial date of entitlement for Medicaid benefits may be as early as the first day of the month in which the individual filed an application for financial or medical assistance, provided all eligibility requirements are met in the month of application. For initial date of entitlement by category reference is made to Title XIX State Plan.

(2) If an individual meets the requirements of 126-360(C) below for retroactive Medicaid, the date of entitlement may be as early as the first day of the third month preceding the month of application.

(3) As SSI recipient who moves into this State from another state shall be eligible for Medicaid beginning with the first day of the month in which he moves into the State.

C. Retroactive Medicaid Eligibility.

(1) Medicaid eligibility may be established retroactively up to the first day of any month in the three month period prior to the month of application provided the individual received Medicaid covered services at any time during that period and the individual would have been eligible for assistance at the time he received the services if he had applied. Persons found ineligible for Medicaid in the current month may be eligible for retroactive Medicaid. Prior approval shall not be required for medical services rendered during a period of retroactive Medicaid eligibility.

(2) Posthumous application may be made on behalf of deceased individuals. The individual must have been eligible for Medicaid when the services were rendered. The application must be filed before the end of the third month following death for any benefits to be received.

D. Medicare. Medicaid recipients who are eligible for Medicare benefits are automatically enrolled in the Supplemental Medical Insurance (SMI) Program (Part B). The State pays the premiums for Medicaid eligible persons who are enrolled in Part B.

E. Agreement With Social Security. The Health and Human Services Finance Commission (Commission) has an agreement with SSA under section 1634 of the Social Security Act for determining Medicaid eligibility for individuals who receive SSI.

126–365. Categorically Needy Eligible Groups.

A. Medicaid eligible persons through the Aid to Families With Dependent Children (AFDC) program are:

(1) All persons in the AFDC budget group.

(2) All children for whom the State makes an adoption assistance or foster care maintenance payment under Title IV E of the Social Security Act.

(3) Families terminated from AFDC because of increased earnings or hours of employment as provided for and limited by Title XIX of the Social Security Act and the federal regulations promulgated in accordance therewith.

(4) Individuals who are denied a cash payment solely because the amount of the AFDC payment would be less than \$10.

(5) Pregnant women who would be eligible for an AFDC cash payment if the child had been born and was living with her in the month of payment and the pregnancy has been medically verified. Income shall be measured against the AFDC total requirements standard for one person.

(6) Individuals who are ineligible for AFDC because of requirements that do not apply under Title XIX of the Social Security Act. These individuals are identified in the Title XIX State Plan for Medical Assistance.

B. Individuals Under Twenty-one (21) With Special Living Arrangements.

(1) Medicaid is available to individuals who are younger than twenty-one (21) years of age, residing within or outside the State in foster homes or private institutions licensed by the Department of Social Services, or who live in foster care homes or institutions licensed by other state agencies, but whose standards have been approved by the Department of Social Services. To be Medicaid eligible, the individual must receive a regular foster care board payment, or a payment for maintenance under a Social Services Block Grant (SSBG) contract, or be supported fully or partially from public funds of any State or local agency. The income and resources available to the individual shall not exceed the appropriate foster home care board payment standard for the individual's age and the AFDC resource limitation.

(2) Hospitalization prior to placement in a substitute care facility may be necessary in certain situations. As long as it is planned for the individual to enter foster care upon release from the hospital and the individual meets all other eligibility criteria for Medicaid as an individual under twenty-one (21) with special living arrangements, the individual may be certified for Medicaid while in the hospital.

(3) An individual who is placed in foster care in emergency placement status under SSBG may be eligible for Medicaid while in the emergency placement, public or private, as long as all eligibility criteria for Medicaid as an individual under twenty-one (21) with special living arrangements are met.

(4) Individuals who are younger than twenty-one (21) years of age and who reside in a public institution or who are inmates of a penal or correctional institution, or of institutions licensed by penal or correctional agencies, are not eligible for Medicaid. Such individuals are not eligible for Medicaid when they are temporarily absent from such institution while residing in a maternity home, foster care home or facility, or a medical facility.

C. Supplemental Security Income (SSI) Recipients.

(1) All individuals, including their categorically eligible spouses, who receive SSI benefits are eligible for Medicaid.

(2) Individuals eligible as essential spouses in December 1973 are eligible for Medicaid. Eligibility is determined in accordance with Title XIX of the Social Security Act and the federal regulations promulgated in accordance therewith.

(3) SSI recipients who are in suspense status due to the development of a representative payee for the individual are eligible for Medicaid.

D. Optional State Supplement (OSS) Recipients. All individual who receive an OSS payment are eligible for Medicaid.

E. Refugee Assistance Recipients.

(1) All persons whose needs are included in a Refugee Assistance payment are eligible for Medicaid.

(2) All persons who are eligible to be included in a Refugee Assistance payment because of limited income and resources, but who desire to receive medical assistance only are eligible for Medicaid.

(3) Refugees who are determined to be medically needy by the "spend-down" method are eligible for Medicaid.

F. 1977 Title II Pass-Along Provision of the Social Security Act. Medicaid is available under this provision to those individuals who lost their eligibility for cash assistance due to a Social Security cost-of-living increase and who meet the requirements of Title XIX of the Social Security Act and the federal regulations promulgated in accordance therewith.

G. Individuals Who Would Be Eligible for Cash Assistance If Outside the Institution.

(1) Medicaid is available to individual who would be eligible for cash assistance if they were not residing in an institution provided they meet the eligibility requirements of Title XIX of the Social Security Act and the federal regulations promulgated in accordance therewith.

(2) Individuals who have no income may also be eligible under this provision provided they have applied for and are awaiting receipt of payment under the SSI program.

H. Institutionalized Individuals Who Are Eligible Under a Special Income Level.

(1) An individual may be eligible for MAO, including a medical institution vendor payment, if he meets all of the following requirements:

(a) Resides in a Title XIX certified medical facility and meets the requirements to be considered institutionalized as defined by Title XIX of the Social Security Act and the federal regulations promulgated in accordance therewith;

(b) Meets SSI criteria for either age, disability or blindness;

(c) Meets all SSI financial eligibility criteria except for the income limitation;

(d) Has been certified by CLTC for the level of care in which he resides.

(2) SSI categorical and financial eligibility criteria are found in Title XVI of the Social Security Act and in the Program Operations Manual System published by the Social Security Administration, U.S. Department of Health and Human Services.

(3) To be eligible for MAO as an aged, blind or disabled person, an individual's or couple's gross monthly income shall not exceed the Medicaid Cap. Gross monthly income is the individual's or couple's total earned and unearned income as defined under the federal regulations of the SSI Program.

(4) An income averaging procedure shall be used for individuals who receive Medicaid and who receive variable income.

I. Individuals receiving Home and Community based Services Who Are Eligible Under a Special Income Level.

(1) An individual living in the community may be eligible for MAO if he meets all of the following requirements:

- (a) Meets SSI criteria for either age, disability or blindness;
- (b) Meets all SSI financial eligibility criteria except for the income limitation;
- (c) Has been certified by CLTC to be eligible for skilled or intermediate nursing care;
- (d) Receives home and community based services provided under a home and community-based waiver.

(2) The criteria found in 126.365 H.(2) through (4) apply to these individuals.

(3) An individual must apply all available income, less allowable exclusions to the cost of waived services. The amount of income to be applied to the cost of waived services shall be determined in accordance with Title XIX of the Social Security Act and the federal regulations promulgated in accordance therewith.

J. Pregnant women and children with family income below the poverty level.

(1) An individual eligible for Medicaid under this category is one who—

- (a) is a pregnant woman whose pregnancy has been medically verified; or, is a child under the age of one year (or as otherwise specified in the Title XIX State Plan); and
- (b) has a countable family income, as determined in accordance with Title XIX of the Social Security Act and federal regulations promulgated in accordance therewith, which is below 100 percent of the federal poverty level (or as otherwise specified in the Title XIX State Plan) for the appropriate family size; and
- (c) meets all non-financial criteria required by Title XIX of the Social Security Act and federal regulations promulgated in accordance therewith.

(2) A pregnant woman who is determined eligible under this category is eligible throughout the term of her pregnancy and remains eligible for sixty (60) days after the end of her pregnancy, regardless of changes in income.

K. Medicaid is available to children under age eighteen (18) who meet AFDC income and resource standards. Eligibility is determined in accordance with Title XIX of the Social Security Act and the federal regulations promulgated in accordance therewith.

L. Children for whom there is in effect a State adoption assistance agreement. An individual eligible for Medicaid under this category is one whom:

- (1) the State adoption agency has determined cannot be placed for adoption without medical assistance because of special needs for medical or rehabilitative care; and
- (2) before the execution of the agreement, had such special need and would have been eligible for Medicaid if the standards and methodologies of the Title IV-E foster care program were applied.

M. Aged, blind and disabled individuals with income below the poverty level.

(1) An individual eligible for Medicaid under this category is one who:

- (a) meets SSI criteria for either aged, disability or blindness;
- (b) has countable income, as determined in accordance with Title XIX of the Social Security Act and federal regulations promulgated in accordance therewith, which is below 100 percent of the federal poverty level (or as otherwise specified in the Title XIX State Plan);
- (c) has countable resources, as determined in accordance with Title XIX of the Social Security Act and federal regulations promulgated in accordance therewith, which is below the level specified in the Title XIX State Plan; and
- (d) meets all non-financial criteria required by Title XIX of the Social Security Act and federal regulations promulgated in accordance therewith.

(2) As allowed by Section 1902(r)(2) of the Social Security Act, the State has elected to use special methodologies to determine income and resource eligibility. These methodologies are specified in the Title XIX State Plan.

- N. Certain disabled children age 18 or under who are living at home.
- (1) Children eligible for Medicaid under this category are children who:
 - (a) live at home;
 - (b) would be eligible for Medicaid under the plan if they were in a medical institution;
 - (c) meet the Supplemental Security Income definition of disability; and
 - (d) have been determined by the State to meet the requirements of Section 1902(e)(3)(B) of the Social Security Act regarding the appropriateness and cost effectiveness of care.
 - (2) Only the income and resources of the children are considered in the financial eligibility determination. Financial eligibility is determined in accordance with Title XIX of the Social Security Act and federal regulations promulgated in accordance therewith.

HISTORY: Amended by South Carolina State Register Volume 20, Issue No. 4, eff April 26, 1996.

126-370. Redetermination of Categorically Needy Eligibility.

Eligibility for continued benefits shall be redetermined at least every 12 months.

126-375. Medical Institution Vendor Payments

A. Vendor payments are made on behalf of eligible individuals to medical institutions in accordance with Title XIX of the Social Security Act and the federal regulations promulgated in accordance therewith.

B. An individual must meet all of the following requirements in order to be eligible for a medical institution vendor payment.

- (1) Meet all eligibility criteria for any eligible group specified in 126-365 and 126-377.
- (2) Reside in a Title XIX certified medical facility which has a current contract with the Department of Health and Human Services.
- (3) Have written documentation from the Department of Health and Human Services or its designee that institutional care is medically necessary, and have an appropriate level of care certified by the Department of Health and Human Services or its designee.
- (4) Apply all available income, less allowable exclusions, to the cost of care. The amount of income to be applied to the cost of care shall be confirmed with the individual and the medical institution.

C. All applicants for Medicaid-sponsored long term care must have medical necessity certified by the Department of Health and Human Services or its designee. This certification includes the designation of the level of care needed by the applicant based on the appropriate Level of Care Criteria (either the South Carolina Level of Care Criteria for Long Term Care or the South Carolina Level of Care Criteria for Intermediate Care Facility/Personswith Intellectual Disability), as developed by the Department of Health and Human Services. Medical necessity and level of care must be certified prior to admission to a long term care facility or if an individual applies for assistance while in a long term care facility, prior to the date Medicaid vendor payment can begin. The Level of Care Criteria, as well as further clarification of these mandatory preadmission requirements, can be found under cover of Medicaid Bulletins issued by the Department of Health and Human Services. These Medicaid Bulletins can be obtained from the office of the Department of Health and Human Services, from any Community Long Term Care area office, or from county Department of Social Services offices.

D. Determination of Recurring Income.

(1) The amount of income which the individual must apply to the cost of care is determined in accordance with Title XIX of the Social Security Act and the federal regulations promulgated in accordance therewith.

(2) In the month of entry into a medical facility from a non-institutional living arrangement, the individual's income shall not be counted as recurring income. In the month of discharge from a medical facility to a non-institutional living arrangement, a portion of the individual's income shall not be counted as recurring income.

(3) An SSI eligible individual entering a medical facility shall not be eligible automatically for a medical institution vendor payment. The SSI recipient's eligibility for Medicare, Special Age Seventy-two Social Security Benefits, Veterans Benefits, or other benefits shall be explored and utilized, if

available. A level of care must be certified by the Department of Health and Human Services or its designee and the monthly recurring income computed. If an individual's SSI is terminated while he is in the institution because of too much income, he may reapply for MAO.

HISTORY: Amended by State Register Volume 16, Issue No. 6, eff June 26, 1992; State Register Volume 20, Issue No. 6, Part 1, eff June 28, 1996.

Code Commissioner's Note

Pursuant to 2011 Act No. 47, §14(B), the Code Commissioner substituted "intellectual disability" for "mental retardation" and "person with intellectual disability" or "persons with intellectual disability" for "mentally retarded".

126-380. Denial, Termination, or Reduction of Benefits.

A. When an individual's Medicaid benefits are denied, discontinued or changed, the individual shall receive notice pursuant to Title XIX of the Social Security Act. The notice shall include an explanation of the individual's right to a fair hearing, the method to obtain a hearing, and the right to representation.

B. Fair hearings shall be conducted pursuant to R126-150.

C. An individual's Medicaid benefits may be continued pending a fair hearing decision in accordance with Title XIX of the Social Security Act and the federal regulations promulgated in accordance therewith.

126-399. Conflict Between State and Federal Regulations.

When the requirements of the State and the Federal regulations are not in agreement, the requirements of the Federal regulations shall prevail.

**ARTICLE 4
PROGRAM EVALUATION**

**SUBARTICLE 1
ADMINISTRATIVE SANCTIONS AGAINST MEDICAID PROVIDERS**

126-400. Definitions.

A. Provider - means an individual, firm, corporation, association or institution which is providing, or has been approved to provide, medical assistance to a beneficiary pursuant to the State Medical Assistance Plan and in accord with Title XIX of the Social Security Act of 1932, as amended.

B. Person - any natural person, company, firm, association, partnership, corporation or other legal entity.

C. Practitioner - means a physician or other health care professional licensed under State law to practice his or her profession.

D. Educational Intervention - means a visit to a provider by a staff member to explain Medicaid Program policies and procedures. This includes instructions on correct billing procedures. Educational intervention may also take the form of a telephone call or letter to a provider calling his or her attention to a particular problem in Program administration or billing practices.

E. Abuse - provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid Program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care.

F. Fraud - an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law. [42 CFR § 455.2].

G. Conviction or convicted - means a judgment or conviction after trial, or the entry of a plea of guilty or a plea of no contest (nolo contendere) in a federal, state or local court, regardless of whether an appeal from that judgment is pending.

H. Exclusion - means that a health care provider, either an individual practitioner or facility, organization, institution, business, or other type of entity, cannot receive Medicaid payment for any health care services rendered. [42 CFR § 455.2].

I. Suspension of Payment - means that upon determination by the Department that there is a credible allegation of fraud against a specified provider for which an investigation is pending under the Medicaid program, all payments pending at the time of determination and all payments for items or services furnished by the specified provider will be retained by the Department until resolution of the investigation, unless the Department determines that good cause to not suspend or to only suspend in part exists, as set forth in 42 CFR § 455.23(e) and § 455.23(f) respectively. [§ 455.23].

J. Termination - occurs when the Medicare program, a State Medicaid program, or Children's Health Insurance Program (CHIP) has taken an action to revoke a provider's billing privileges, a provider has exhausted all applicable appeal rights or the timeline for appeal has expired, and there is no expectation on the part of a provider or supplier or the Medicare program, State Medicaid program, or CHIP that the revocation is temporary. The requirement for termination based upon a termination in another program applies in cases where providers, suppliers, or eligible professionals were terminated or had their billing privileges revoked for cause which may include reasons based on fraud, integrity, or quality. [Section 6501 of the Affordable Care Act amended section 1902(a)(39) of the Social Security Act (the Act) and requires State Medicaid agencies to terminate the participation of any individual or entity if such individual or entity is terminated under Medicare or under the Medicaid program or CHIP of any other state].

K. Suspension - means that items or services furnished by a specified provider who has been convicted of a program-related offense in a Federal, State, or local court will not be reimbursed under Medicaid.[42 CFR § 455.2].

HISTORY: Amended by SCSR42-5 Doc. No. 4746, eff May 25, 2018.

126-401. Sanctions.

A. The Administrator of the Title XIX Single State Agency may invoke one (1) or more of the following administrative sanctions against a Medicaid provider who has been determined to have abused the Medicaid Program:

- (1) Educational Intervention;
- (2) Postpayment Review of Claims;
- (3) Prepayment Review of Claims;
- (4) Referral to Licensing/Certifying Boards or Agencies;
- (5) Peer Review;
- (6) Suspension;
- (7) Termination.

B. The Administrator of the Title XIX Single State Agency may invoke one (1) or more of the following administrative sanctions against a Medicaid provider who has been determined to be guilty of fraud or convicted of a crime related to his or her participation in Medicare or Medicaid, or for any reason for which the Secretary of the United States Department of Health and Human Services could exclude an individual or entity under 42 CFR §§ 1001 and 1003. [42 CFR § 1002.210]:

- (1) Suspension;
- (2) Termination;
- (3) Exclusion.

HISTORY: Amended by SCSR42-5 Doc. No. 4746, eff May 25, 2018.

126-402. Factors for Sanction.

The factors to be considered in determining sanctions shall include, but not be limited to, the following:

- A. Seriousness of the offense(s);
- B. Extent of violation(s);

- C. History of prior violation(s);
- D. Prior imposition of sanction(s);
- E. Provider failure to obey program rules and policies as specified in the appropriate Provider Manual or other official notices.

HISTORY: Amended by SCSR42-5 Doc. No. 4746, eff May 25, 2018.

126-403. Grounds for Sanction.

The grounds for sanctioning providers shall include, but not be limited to, the following:

- A. Presenting or causing to be presented for payment any false or fraudulent claim for services or merchandise.
- B. Submitting or causing to be submitted false information for the purpose of obtaining greater compensation than that to which the provider is legally entitled, including charges in excess of the fee schedule or usual and customary charges.
- C. Submitting or causing to be submitted false information for the purpose of meeting prior authorization requirements.
- D. Failure to disclose or make available to the Single State Agency or its authorized agent records of services provided to Medicaid beneficiaries and records of payment made therefore.
- E. Continuing a course of conduct deemed abusive of the Medicaid Program after receiving written notice from the Single State Agency that said conduct must cease, provided that the written notice shall specify the practices deemed abusive.
- F. Breach of the terms of the Medicaid provider agreement or failure to comply with the terms of provider certification on the Medicaid claim form.
- G. Over-utilizing the Medicaid Program by including, furnishing, or otherwise causing a beneficiary to receive service(s) or merchandise not otherwise required by the beneficiary.
- H. Rebating or accepting a fee or portion of a fee or charge for a beneficiary referral.
- I. Submission of a false or fraudulent application for provider status.
- J. Conviction against a provider for a criminal offense related to his or her involvement in the Medicaid or Medicare Program.
- K. Failure to meet standards required by State or Federal law for Medicaid participation (i.e., failed to meet the licensing requirements constituting minimum qualification).
- L. Exclusion from Medicare because of fraudulent or abusive practices (i.e., terminated or suspended from participation in the Medicare Program under 42 CFR, Part 1001.)
- M. Failure to correct deficiencies in provider operations after receiving written notice of these deficiencies from the Single State Agency.
- N. Failure to repay or make arrangements for the repayment of identified overpayments or otherwise erroneous payments.
- O. Termination for cause under Medicare or under the Medicaid or CHIP program of any other State [42 CFR § 455.416 and Section 6501 of the Affordable Care Act]

HISTORY: Amended by SCSR42-5 Doc. No. 4746, eff May 25, 2018.

126-404. Fair Hearings.

- A. Any Medicaid provider who has been notified in writing by the Single State Agency of a proposed recoupment of overpayments, a proposed exclusion, suspension or termination due to an administrative determination of abuse, or a proposed exclusion, suspension or termination due to a program related conviction in a state or federal court, may exercise his right to a fair hearing pursuant to R.126-150 prior to implementation of the proposed action. This subparagraph applies only to postpayment reviews of providers which are conducted by the Department. Further, this subparagraph shall not apply in the case of a provider who has been excluded, suspended or terminated from participation in the Medicare program, in which case the provisions of 42 CFR, Part 1001, shall apply.
- B. Any individual Medicaid practitioner who has been convicted of a criminal offense related to his involvement in the Medicare or Medicaid Program and who is subsequently excluded, suspended or

terminated pursuant to 42 CFR Section 402, Subpart C, may exercise his appeal rights as set forth in the written notice of exclusion, suspension or termination from the Centers for Medicare and Medicaid Services. Appeals to the Centers for Medicare and Medicaid Services shall be processed exclusively in accordance with 42 CFR Part 1005.

HISTORY: Amended by State Register Volume 20, Issue No. 6, Part 1, eff June 28, 1996; SCSR42-5 Doc. No. 4746, eff May 25, 2018.

126-405. Reinstatement.

An individual or entity who has been excluded from Medicaid may be reinstated only by the Medicaid agency that imposed the exclusion. An individual or entity may submit to the State agency a request for reinstatement at any time after the date specified in the notice of exclusion [42 CFR § 1002.214(b) and (c)].

HISTORY: Amended by SCSR42-5 Doc. No. 4746, eff May 25, 2018.

SUBARTICLE 2 PROGRAM INTEGRITY

126-425. Beneficiary Utilization.

A. Definitions.

(1) The Division of Program Integrity of the South Carolina Department of Health and Human Services (DHHS) is designed to safeguard against unnecessary, harmful, wasteful, and uncoordinated utilization of services by Medicaid eligible beneficiaries and health care providers.

(2) Medicaid Beneficiary - an individual who has been determined to be eligible for health services as described in the State Plan under Title XIX and Title XXI of the Social Security Act, as amended.

(3) Beneficiary Profile - a comprehensive statistical and utilization profile of a Medicaid beneficiary who has deviated from predefined thresholds, standards of medical care, and other criteria for the purposes of analysis and review.

(4) Misutilization (“misuse”) - overuse, underuse, harmful, wasteful, and uncoordinated use of Medicaid services or improper or incorrect use of services provided under the Medicaid Program, whether intentional or unintentional.

(5) Restriction (“restricted”) - The limitation of a Medicaid beneficiary to Medicaid services provided by a designated primary physician practitioner, pharmacy, hospital, or mental health provider for other than emergency health care. A restriction may be to more than one provider. A designated primary physician practitioner may make referrals to other health care providers, which will not be affected by the restriction designation.

(6) Provider - an individual, partnership, corporation, association, or institution that is eligible to provide medical assistance to a beneficiary pursuant to the State Medical Assistance Plan in accordance with Title XIX and Title XXI of the Social Security Act, as amended. A provider must be licensed, as applicable, under State law, is in good standing with applicable professional review boards, has not had a license revoked or suspended, and has not been convicted of fraud in any legal jurisdiction.

(7) Practitioner - a physician or other health care professional licensed under State law to practice his or her profession, is in good standing with applicable professional review boards, has not had a license revoked or suspended, and has not been convicted of fraud in any legal jurisdiction.

(8) Treatment Pathway - is the most appropriate medical condition specific treatment protocol. Treatment pathways have been researched and approved by professional associations, provide desired outcomes, include definitive evaluation and re-evaluation plateaus, offer a coordinated health team approach to care, eliminate duplication of costly services, and reduce errors.

(9) Medically Reasonable and Necessary (“medically necessary”) - means procedures, treatments, medications or supplies ordered by a physician, dentist, chiropractor, mental health care provider, or other approved, licensed health care practitioner to identify or treat an illness or injury. Procedures, treatments, medications or supplies must be administered in accordance with recognized

and acceptable medical and/or surgical discipline at the time the patient receives the service and in the least costly setting required by the patient's condition. All services administered must be in compliance with the patient's diagnosis, standards of care, and not for the patient's convenience. The fact that physician prescribed a service or supply does not deem it medically necessary.

B. Beneficiary Policies.

(1) The services that are governed by this program are as follows:

- (a) All medical services rendered by a Medicaid provider for non-emergency services;
- (b) Beneficiaries' use of Medicaid services;

(2) Services that are not governed by this program are as follows:

(a) Emergency services which are necessary to prevent death or serious impairment of the health of a beneficiary;

(b) Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services;

(3) Beneficiary profiles shall be reviewed to identify potential utilization or compliance issues.

(4) Providers shall refer suspected misusers of Medicaid services to the DHHS.

(5) Beneficiaries identified as suspected misusers of Medicaid services will be notified in writing that he/she will be restricted subject to paragraph A (5). The period of restriction shall be in accordance with 42 CFR 431.54(e). DHHS shall monitor restricted beneficiaries' utilization patterns.

(6) The factors to be considered in making a determination whether to implement a restriction shall include all or some of the following:

- (a) Medical factors;
- (b) Patient utilization history;
- (c) The degree of aberrancy;
- (d) Any history of prior misutilization;
- (e) Utilization patterns inconsistent with their peers;
- (f) Utilization patterns inconsistent with treatment pathways;
- (g) Evidence of abusive, duplicative, and wasteful utilization practices;
- (h) Evidence of drug-seeking behaviors;
- (i) Evidence of utilization patterns that could cause harm to the beneficiary;
- (j) The degree of compliance with medical advice and treatment pathways;
- (k) Evidence that a beneficiary's medical outcomes and health status may be improved by following treatment pathways and coordinated care.

(7) Rights and conditions of beneficiary during restriction period.

(a) Beneficiaries will be notified by mail of a pending restriction or action subject to 42 CFR 431.206 through 42 CFR 431.214.

(b) Beneficiaries are given freedom of choice of their primary providers. If a beneficiary does not select a primary provider, DHHS may select one for the beneficiary.

(c) A beneficiary will be released from restriction upon DHHS determination that the beneficiary's service utilization patterns are in compliance with treatment pathways and consistent with their medical needs.

(8) Fair Hearing - any Medicaid beneficiary who has been notified in writing by DHHS or its designee of a pending restriction due to misutilization of Medicaid services may exercise his/her right to a fair hearing. Notice will be given pursuant to 42 CFR 431, Subpart E and the Fair Hearing will be conducted pursuant to R.126-150 et seq. and 42 CFR 431, Subpart E.

HISTORY: Amended by State Register Volume 28, Issue No. 5, eff May 28, 2004; SCSR42-5 Doc. No. 4746, eff May 25, 2018.

ARTICLE 5
MEDICALLY INDIGENT ASSISTANCE PROGRAM (MIAP)

SUBARTICLE 1
ELIGIBILITY FOR THE MEDICALLY INDIGENT ASSISTANCE PROGRAM (MIAP)

126–500. Definitions.

- A. “Department” means the South Carolina Department of Health and Human Services.
- B. “County resident” means an individual who is a state resident and who lives in a particular county. For the purpose of determining eligibility for the MIAP, an individual who does not have an established residence in a particular county is considered a resident of the county in which the admitting hospital is located. For the purpose of computing the county assessment pursuant to 44–6–146(B), Code of Laws of South Carolina (1976), as amended, an individual with no established residence shall be excluded from the computation.
- C. “Designee” means the entity with which the county government has arranged to determine eligibility for the MIAP.
- D. “Family” means the applicant and legally responsible relatives who live in the same household. If the applicant is legally or financially dependent upon another person, the applicant, the responsible person, and all persons related to the applicant by birth, marriage, or adoption who are also legally or financially dependent upon the responsible person and who reside in the same household as the responsible person are considered members of the same family. If the applicant is not legally or financially dependent upon another person, the applicant and all persons related to the applicant by birth, marriage, or adoption who are also legally or financially dependent upon the applicant and who reside in the same household as the applicant are considered members of the same family.
- E. “General hospital” means any hospital licensed as a general hospital by the South Carolina Department of Health and Environmental Control.
- F. “Gross annual income” means the total yearly income, before deductions, of the applicant and his family.
- G. “Hospital bill” means the allowable payment under the Medicaid program for inpatient hospital services.
- H. “Inpatient hospital services” are those items and services ordinarily furnished by a hospital for the care and treatment of in patients. Such services must be medically justified, documented by the physician’s records, and comply with the requirements of the Professional Review Organization. Services covered, non-covered and restricted are defined in the MIAP Manual.
- I. “Poverty guidelines” are the federal poverty income guidelines which are issued by the United States Department of Health and Human Services.
- J. “State resident” means a person who is domiciled in South Carolina. A domicile once established is lost or changes only when an individual moves to a new locality with the intent to abandon his old domicile and the intent to live permanently or indefinitely in the new location. For the purposes of the MIAP, a migrant or seasonal farm worker is a resident of the State provided he has not established a domicile in another State.
- K. “Third party payor” means any individual, entity, or program that is or may be liable to pay all or part of the medical cost of injury, disease, or disability of the individual. It includes Medicare, insurance, employee benefit plans, Medicaid, any other State or Federal program, or other persons or agencies required by law or a court order to provide medical care for an individual.
- L. “Liquid assets” are those assets which are in cash or payable in cash on demand. Liquid assets also include financial instruments convertible into cash within twenty workdays.
- M. “Financially dependent” means an individual who meets the federal criteria of “dependent” for income tax purposes.

HISTORY: Amended by SCSR42–5 Doc. No. 4746, eff May 25, 2018.

126–505. Responsibilities for Eligibility Determination.

A. The Department shall develop uniform criteria and materials for statewide use. A detailed description of the criteria, procedures, and materials which include an application form and letter of notification may be found in the MIAP Manual. Each county is responsible for determining eligibility in accordance with the policies and procedures in the MIAP Manual. If a county fails to meet this responsibility, claims for the county's residents may be suspended until it is determined that the county is fulfilling its responsibility.

B. The county government shall make arrangements for the determination of eligibility for the MIAP for its residents. The county shall notify the Department of who is designated to determine eligibility in the county. The Department shall provide a listing of each county's designee to each general hospital and to the Chief Administrative Officer and Clerk to County Council in each county. If a county intends to review claims prior to the submission of such claims for payment, the county must inform the Department of its intent to review claims.

C. General hospitals shall inform patients of the existence of the MIAP and shall refer the patient for an application if it is determined that the patient has no means to pay for hospital services. General hospitals shall submit claims to the Department. If a county has elected to review claims prior to submission to the Department, it must review the claims within fifteen (15) working days from the date the claim is provided by the hospital. If no response is received from the county within fifteen (15) working days, the hospital shall forward the claim to the Department.

HISTORY: Amended by SCSR42–5 Doc. No. 4746, eff May 25, 2018.

126–510. Application Process.

When it is determined that an individual needs hospitalization and that he may qualify for assistance through the MIAP, the procedures stated below shall be followed.

A. For nonemergency admissions, the patient shall be referred to the designee in the county of residence for an eligibility determination. The designee shall notify the patient and the admitting hospital or physician of the outcome of the eligibility determination. Eligibility shall be determined prior to admission.

B. For emergency admissions, the hospital shall admit the patient and obtain a signed application from the applicant, his relative or other individual authorized to act on his behalf. The hospital shall collect information pertaining to the individual's eligibility. The hospital shall then forward the information to the designee in the individual's county of residence for processing. The county designee shall notify the patient and the hospital of the outcome of the eligibility determination in accordance with Section H of this subpart.

C. Eligibility shall be determined on an episodic basis. A new application is required for each period of hospitalization. Exception: If the patient is readmitted to the hospital within thirty (30) days of the date of discharge, he is not required to file another application; however, it must be determined that the patient's financial circumstances have not changed.

D. The application must be submitted by the patient or a responsible person acting on his behalf. If the applicant is not capable of submitting his own application and he has no one to act on his behalf, the hospital may submit the application.

E. A retroactive application may be filed only if an individual failed to apply at the time of hospitalization. The individual must be able to establish that he was eligible at the time of hospitalization. All retroactive applications must be filed within one (1) year after discharge from the hospital. Retroactive sponsorship by MIAP may be made only if the program had not sponsored \$15 million in unreimbursed hospital care during the year in which the hospitalization occurred. These procedures also apply if an application is made on behalf of a deceased individual.

F. The applicant shall furnish required documentation to establish eligibility. The designee shall assist the applicant in obtaining needed documentation when the applicant is incapable of obtaining such documentation.

G. Disposition of applications for assistance through the MIAP shall be made within fifteen (15) working days unless an eligibility determination for other benefits such as Medicaid must be made prior to certification for payment or unless more time is needed to obtain adequate documentation. If

disposition of an application is not made within fifteen (15) working days, the reason for delay must be documented. This time frame, is separate from the fifteen (15) working days that a county is allowed for the review of hospital claims, if it elects to do so.

For applicants who are potentially eligible for Medicaid, the MIAP application cannot be approved until the applicant has applied for and been denied Medicaid benefits for a reason other than those identified in the MIAP Manual. The fifteen (15) day time frame does not apply in this situation.

H. The designee shall provide written notification to applicants and providers of the decision on MIAP applications.

I. If an applicant disagrees with the decision made on his case, he may request a reconsideration at the county level. This reconsideration request must be made within thirty (30) days of the notification of the decision. The reconsideration decision shall be made by an individual(s), other than the person who made the eligibility determination, designated by the county's chief administrative officer. If the applicant disagrees with the reconsideration decision, he may request a fair hearing from the Appeals Unit of the Department. This request must be made in writing within thirty (30) days of the reconsideration decision. The fair hearing will be conducted in accordance with the Department Appeals and Hearing Regulations, R.126-150 et seq.

HISTORY: Amended by SCSR42-5 Doc. No. 4746, eff May 25, 2018.

126-515. Non-Financial Eligibility Requirements.

In order to be eligible for assistance from the MIAP, an individual must meet the following non-financial eligibility criteria.

A. Residence. The individual shall be a resident of the State. A migrant or seasonal farm worker shall be considered a resident of the State provided he has not established a domicile in another State.

For purposes of the MIAP, a financially dependent student is a resident of the State and county in which his parents reside. If the student's parents do not live in the same home, the financially dependent student is a resident of the State and county where the parent with legal custody resides.

B. Citizenship and Alienage. An individual must be a citizen of the United States or an alien admitted for permanent residence or an alien permanently residing in the United States under color of law.

C. Institutional Status. Individuals who are inmates or residents of public institutions are not eligible for assistance through the MIAP. This includes inmates of correctional facilities who may be temporarily absent from the facility due to hospitalization.

Exception: Inmates of county detention facilities who are awaiting trial or whose cases have not been adjudicated shall be eligible provided they meet all other eligibility requirements.

126-520. Financial Eligibility Requirements.

The following elements are considered in determining eligibility for assistance through the MIAP.

A. Family Composition. For details, refer to the definition of family at 126-500(D). If the applicant is a minor child, his stepparent is considered a member of the family only if the stepparent claims the child as an income tax dependent. If the applicant is an adult, his parents or siblings who reside in the household are considered in the family only if one claims the other as an income tax dependent. The income and resources of all members of the applicant's family must be considered in computing the income.

B. Financial responsibilities of relatives. Spouses are responsible for spouses and parents are responsible for minor children. Stepparents are responsible for stepchildren only if the stepchildren meet the federal definition of "dependent" for income tax purposes.

C. Income Levels. Only those individuals whose gross family income is equal to or less than one hundred percent of the poverty guidelines may qualify for full sponsorship through the MIAP. Only those individual whose gross family income is between one hundred and two hundred percent of the poverty guidelines may qualify for partial sponsorship through the MIAP.

D. Computation of income. The gross annual income of the individual and his family is measured against the annual poverty guidelines for the appropriate size family. Gross annual income is determined in accordance with the guidelines found in the MIAP Manual.

E. Ownership of Resources. Resources must be within the limitations described below:

1. Home property. Home property is the applicant's principal place of residence. It includes the home and all contiguous property. The value of a farm of less than fifty (50) acres on which an individual or his family resides and has resided for at least twenty-five (25) years shall be totally excluded from the resources computation. The equity value of home property other than a family farm as defined above shall not exceed \$35,000.00. A mobile home may be considered home property if it is the individual's principal place of residence.

2. Non-home real property and taxable personal property. The individual's or family's total equity interest in non-home real property and taxable personal property such as motor vehicles shall not exceed \$6,000.00.

3. Liquid assets. The individual's or family's total liquid assets must be equal to or less than \$500.00.

An individual with excess liquid assets may establish eligibility if he and other members of his family spend the excess toward the payment of valid debts as defined in the MIAP Manual.

4. Household effects. Household effects such as furniture, kitchen utensils, etc., are not considered in the resource computation.

F. Transfer of Resources. An individual or his family who transferred resources without receiving full compensation within three (3) months prior of the period of hospitalization for which his application for assistance through the MIAP is made shall not be eligible. Such individual and his family will continue to be ineligible for one year from the date of transfer or until he establishes that full compensation has been received, whichever is earlier.

SUBARTICLE 2 COVERED SERVICES

126-530. Services Covered by the Medically Indigent Assistance Program.

A. Except as otherwise provided in this section, only inpatient hospital services which are covered by the South Carolina Medicaid Program as inpatient hospital services shall be covered by the MIAP.

B. Psychiatric inpatient hospital services shall be limited to emergency admissions. The standard for an emergency admission shall be the physician's belief that the person is mentally ill and because of his condition is likely to cause serious harm to himself or others if not immediately hospitalized.

126-535. Sponsorship From the Medically Indigent Assistance Program.

A. Payments shall be made only to general hospitals.

B. Individuals shall not be sponsored by the MIAP until all other means of reimbursement or service provision have been exhausted. This includes payments from third party sources defined in R126-500 K. This does not include payments by county indigent programs.

C. Rates for hospital reimbursement shall be prospectively determined. Payment from all sources shall not exceed the prospectively determined rate.

D. Full sponsorship for inpatient hospital services is available for eligible individuals whose gross family income is equal to or less than one hundred (100) percent of the poverty guidelines.

E. Partial sponsorship for inpatient hospital services is available for eligible individuals whose gross family income is between one hundred (100) and two hundred (200) percent of the poverty guidelines. Partial sponsorship is based on a sliding scale which is calculated by determining the percentage by which the individual's gross family income exceeds the poverty guidelines for the appropriate size family, multiplied by an amount which is equal to 1% of the mean MIAP payment amount. The MIAP sponsorship shall be determined based on the following formula: the prospectively determined rate minus all third party payments, excess liquid assets paid to the hospital, and the sliding scale amount for which the individual is responsible.

126-540. Recovery by the Medically Indigent Assistance Program.

A. The MIAP shall be reimbursed if an individual or the services delivered to that individual are later determined to be ineligible for coverage.

B. The ineligible person or the person for whom ineligible services are provided must reimburse the hospital to which the MIAP payment was made. The hospital will then reimburse the Department the amount reimbursed to the hospital by that person.

HISTORY: Amended by SCSR42-5 Doc. No. 4746, eff May 25, 2018.

SUBARTICLE 3 PAYMENT PROCESS

126-560. The Department shall use a prospective payment system which considers diagnostic related groupings and per diem costs to reimburse hospitals for inpatient services provided to Medically Indigent beneficiaries.

A. The method for processing and payment of claims shall be an automated system totally dedicated to the MIAP and incorporated into the MIAP Manual.

B. Providers may seek a correction to the statistical calculation which establishes the maximum allowable payment rate by requesting in writing a reconsideration of such rate to:

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

If the provider disagrees with the decision of the Department, he may appeal that decision in accordance with R.126-150 et seq.

HISTORY: Amended by SCSR42-5 Doc. No. 4746, eff May 25, 2018.

SUBARTICLE 4 COUNTY ASSESSMENTS

126-570. Grace Period.

County Assessments shall be paid in accordance with the provisions of 44-6-146(C) of the 1976 Code, as amended. The grace period referred to in this section shall be ten (10) working days from the date the assessment was originally due. The assessment must be paid in full; however, assessments which are not paid within the grace period are subject to monetary penalties as defined in 44-6-146(C). The penalty and/or interest payments may be waived if a county submits evidence to substantiate that:

a county is declared a disaster area; or,
a change adversely affects the economic condition of a county.

Counties which seek a waiver of the penalty and/or interest must submit a written request from the Chief Executive Officer of the county to:

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

HISTORY: Amended by SCSR42-5 Doc. No. 4746, eff May 25, 2018.

ARTICLE 7 SOCIAL SERVICES BLOCK GRANTS [DELETED]

126-710. [Deleted]

HISTORY: Former Regulation, titled General, deleted by SCSR42-5 Doc. No. 4746, eff May 25, 2018.

126-720. [Deleted]

HISTORY: Former Regulation, titled Scope of Program and Services, deleted by SCSR42-5 Doc. No. 4746, eff May 25, 2018.

126-730. [Deleted]

HISTORY: Former Regulation, titled **Persons Eligible to Receive Social Services**, deleted by SCSR42-5 Doc. No. 4746, eff May 25, 2018.

126-740. [Deleted]

HISTORY: Former Regulation, titled **Application Procedures**, deleted by SCSR42-5 Doc. No. 4746, eff May 25, 2018.

126-750. [Deleted]

HISTORY: Former Regulation, titled **Client Right to Appeal**, deleted by SCSR42-5 Doc. No. 4746, eff May 25, 2018.

126-799. [Deleted]

HISTORY: Former Regulation, titled **Prior Regulations**, deleted by SCSR42-5 Doc. No. 4746, eff May 25, 2018.

ARTICLE 8

INTERMEDIATE SANCTIONS FOR MEDICAID CERTIFIED NURSING FACILITIES

(Statutory Authority: 1976 Code Sections 44-6-90, 44-6-540)

126-800. Definitions.

A. Administrator of the State Medicaid Agency means the Executive Director of South Carolina Department of Health and Human Services.

B. Annual Standard Survey means an annual standard survey conducted on each nursing facility, without prior notice to the facility. The survey may occur as early as nine months, but shall not be later than fifteen months after the date of the nursing facility's previous standard survey. The statewide average interval between standard surveys shall not exceed twelve months.

C. Certification means the State Survey Agency's determination that a nursing facility meets the requirements for participation in the Medicaid program.

D. Credible allegation means a statement or documentation which must be submitted to the Centers for Medicare and Medicaid Services (CMS) of the United States Department of Health and Human Services (USDHHS) when a nursing facility has had serious deficiencies resulting in imminent action to terminate the provider's certification. The statement must indicate how deficiencies will be corrected and problems resolved and be realistic in terms of the possibility of correction by specified deadlines.

E. Credible Certified Notice of Correction means a certification letter from the Nursing Facility to the State Survey Agency and the Medicaid Agency, stipulating that deficiencies noted in the most recent survey and due to be corrected by the last date in an accepted credible allegation or in an accepted plan of correction, have been corrected as of the date of the certification letter. Credibility shall be validated upon the next Survey Agency revisit, and penalties shall cease or escalate from the date of the certified notice in accordance with procedures in Section 126-840. The statement, "I certify that" must precede the statement of correction.

F. Deficiency means non-compliance with requirements of participation for nursing facilities as mandated by Federal Regulations.

G. Immediately Jeopardizes the Health or Safety of Residents means that conditions exist which pose a high probability that serious harm or injury to patients could occur at any time, or already has occurred and may well occur again if patients are not protected effectively from the harm (An immediate and serious threat need not result in actual harm to the resident. The threat of probable harm is perceived as being as serious or significant). The only acceptable corrective action is the immediate elimination of the conditions which immediately jeopardize the resident's health and safety.

H. Medicaid is the common name for Title XIX of the Social Security Act.

I. Nursing Facility means a facility with an organized nursing staff to maintain and operate organized facilities and services to accommodate two or more non-related persons over a period exceeding twenty-four hours, which is operated either in connection with a hospital or as a free standing facility for the express or implied purpose of providing nursing care for persons who are not in need of hospital care, and in which all nursing care is prescribed by or performed under the direction of persons currently licensed to practice medicine in the State of South Carolina. Nursing care consists of nursing services requiring knowledge, judgment, and skill in caring for the sick.

J. Recurring Deficiency means a deficiency, cited by the State Survey Agency during a current survey, that has the exact same tag number but a different reason from the one cited during the previous survey.

K. Repeat Deficiency means a deficiency, cited by the State Survey Agency during a current survey, that has the exact same tag number as cited for the exact same reason in a previous survey.

L. Requirements of Participation means the requirements a nursing facility must meet in order to receive payment under the state's Medicaid program.

M. Substantial Risk to Health and Safety of Residents means conditions exist which over time if not corrected, will likely result in harm or injury to patients.

N. State Medicaid Agency means Department of Health and Human Services (SCDHHS).

O. State Survey Agency means the Department of Health and Environmental Control (DHEC).

P. Tag Number means a reference number which identifies a particular Code of Federal Regulation regulatory statement.

Q. Temporary Management/Receivership means the appointment of a substitute manager or administrator, with powers, as enumerated in the statute, by the court.

HISTORY: Amended by SCSR42-5 Doc. No. 4746, eff May 25, 2018.

126-810. Imposition of Sanctions.

The Administrator, or his designee, of the State Medicaid Agency may apply one or more of the following sanctions against a Medicaid nursing facility which has failed to correct deficiencies or make acceptable progress toward correction of deficiencies.

1. Deny payment for all individuals under the Medicaid program.
2. Deny payment for new admissions under the Medicaid program.
3. Assess and collect monetary penalties in accordance with Sections 126-830 and 126-850 of these regulations.
4. Seek court appointment of temporary management.
5. Transfer of residents.
6. Closure of a facility and transfer of residents.

HISTORY: Amended by SCSR42-5 Doc. No. 4746, eff May 25, 2018.

126-820. Factors for Sanctions.

The factors to be considered in determining sanctions shall include, but are not limited to, the following:

A. Seriousness of the deficiencies involves a determination of whether the deficiencies have a direct or indirect relationship to resident health, safety, and welfare and whether the deficiencies create conditions which present substantial threat or immediate jeopardy to the health and safety of residents.

B. Extent of deficiencies involves a determination of the number of requirements violated within a major category of requirements of participation in the Medicaid program and whether the number of patients potentially impacted is isolated, moderate, or widespread.

C. History of prior deficiencies involves a determination of whether the nursing facility has repeat or recurring deficiencies from a previous annual standard survey.

126–830. Assessment of Sanctions.

The Administrator, or his designee, of the State Medicaid Agency may impose penalties in accordance with Section 126–840, Schedule of Sanctions of these regulations.

Civil monetary penalties under each class shall be assessed based on an amount per bed with the maximum monetary penalties adjusted based on the number of beds in the facility. The ceiling for maximum penalties shall be based on a facility size of 300 beds.

Repeat deficiencies, identified from a previous annual standard survey, may be assessed at double the scheduled amount.

Recurring deficiencies identified from previous annual standard survey, may be assessed monetary penalties at one and one half times the scheduled amount.

Monetary penalties levied after the first and subsequent survey revisits shall be assessed from the date indicated in the schedule of sanctions until the earlier of the next survey revisit or a credible certified notice of correction from the facility that deficiencies due to be corrected in accordance with the last date in a credible allegation or an accepted plan of correction have been corrected as of the date of the certified letter. Credibility shall be validated upon the Survey Agency revisit and penalties shall cease for corrected deficiencies or be escalated to the next level for uncorrected deficiencies from the date of the certified letter.

HISTORY: Amended by SCSR42–5 Doc. No. 4746, eff May 25, 2018.

126–840. Schedule of Sanctions.

CLASS I DEFICIENCY:

A. Violation of requirements which present an indirect relationship to resident health, safety or welfare, and which does not create a substantial and/or immediate risk to health and safety.

B. Remedies/Sanctions:

1. Deny payment under the Medicaid program for any new admissions from the date of issuance of a certified notice to the facility when the facility has failed to correct deficiencies within this class within 90 days of the annual standard survey exit date.

2. Assess and collect monetary penalties up to \$500 per day retroactive to the exit date of the standard annual survey for deficiencies in this class which remain uncorrected at the time of the first survey revisit.

3. Assess and collect monetary penalties up to \$990 per day retroactive to the exit date of the first survey revisit for deficiencies in this class which remain uncorrected at the time of a second survey revisit.

4. Assess and collect monetary penalties up to \$1485 per day retroactive to the exit date of the second survey revisit for deficiencies which remain uncorrected at the time of the third survey revisit.

5. Deny payment under the Medicaid program 30 days from decertification date imposed by the State Survey Agency.

CLASS II DEFICIENCY:

A. Violation of requirements which presents a direct relationship to the health, safety or welfare, of residents but which does not create a substantial and/or immediate risk to health and safety.

B. Remedies/Sanctions:

1. Deny payment under the Medicaid program for any new admissions from the date of issuance of a certified notice to the facility when the facility has failed to correct deficiencies within this class within 90 days of the annual standard survey exit date.

2. Assess and collect monetary penalties up to \$750 per day retroactive to the exit date of the standard annual survey for deficiencies in this class which remain uncorrected at the time of the first survey revisit.

3. Assess and collect monetary penalties up to \$1500 per day retroactive to the exit date of the first survey revisit for deficiencies in this class which remain uncorrected at the time of a second survey revisit.

4. Assess and collect monetary penalties up to \$2250 per day retroactive to the exit date of the second survey revisit for deficiencies which remain uncorrected at the time of the third survey revisit.

5. Deny payment under the Medicaid program 30 days from decertification date imposed by the State Survey Agency.

CLASS III DEFICIENCY:

A. Violation of requirements which poses a substantial risk to the health and safety of residents.

B. Remedies/Sanctions:

1. Deny Payment under the Medicaid program for any new admissions from the date of issuance of a certified notice to the facility when conditions exist that pose substantial risk to the health and safety of residents or when the facility has failed to correct deficiencies within 30 days of any survey by the State Survey Agency or the Centers for Medicare and Medicaid Services, United States Department of Health and Human Services.

2. Assess and collect monetary penalties up to \$900 per day retroactive to the exit date of the standard annual survey for deficiencies in this class which remain uncorrected at the time of the first survey revisit.

3. Assess and collect monetary penalties up to \$1800 per day retroactive to the exit date of the first survey revisit for deficiencies in this class which remain uncorrected at the time of a second survey revisit.

4. Assess and collect monetary penalties up to \$2400 per day retroactive to the exit date of the second survey revisit for deficiencies which remain uncorrected at the time of the third survey revisit.

5. Seek circuit court appointment of temporary management to effect an orderly closure when facility management is judged unable or unwilling to correct the deficiencies in this class by the dates stipulated in an accepted plan of correction or in an accepted credible allegation.

6. Deny payment under the Medicaid program 30 days from decertification date imposed by the State Survey Agency.

CLASS IV DEFICIENCY:

A. Violation of requirements which immediately jeopardizes the health and safety of residents.

B. Remedies/Sanctions:

1. Deny payment under the Medicaid program for any new admissions from the date of issuance of a certified notice to the facility when conditions exist that pose immediate jeopardy to health and safety.

2. Assess and collect monetary penalties up to \$1200 per day retroactive to the exit date of the standard annual survey for deficiencies in this class which remain uncorrected at the time of the first survey revisit.

3. Assess and collect monetary penalties up to \$2250 per day retroactive to the exit date of the first survey revisit for deficiencies in this class which remain uncorrected at the time of a second survey revisit.

4. Assess and collect monetary penalties up to \$2500 per day retroactive to the exit date of the second survey revisit for deficiencies which remain uncorrected at the time of the third survey revisit.

5. Initiate emergency action in a court of competent jurisdiction to appoint a receiver to effect an orderly closure.

6. Deny payment under the Medicaid program 30 days from decertification date imposed by the State Survey Agency.

HISTORY: Amended by SCSR42-5 Doc. No. 4746, eff May 25, 2018.

126–850. Levying of Sanctions.

Civil monetary penalties will be collected through an adjustment to reimbursement due nursing facilities or through other appropriate methods.

Denial of payment under the state plan shall be made through suspension or termination of payment.

ARTICLE 9

OPTIONAL STATE SUPPLEMENTATION PROGRAM

126–910. Program Definitions.

A. Optional State Supplementation (OSS) Program — a State-funded program that provides a cash benefit payment that supplements an eligible individual's countable income up to the net income limitation. This supplementation, in conjunction with the individual's countable income (less any program allowances or deductions) is intended to permit the individual to pay for services provided by a licensed community residential care facility that participates in the OSS Program, with the charges for such services being subject to the applicable OSS facility rate.

B. OSS Facility Rate — the maximum rate established by the South Carolina legislative budgetary process that a community residential care facility participating in the OSS Program may charge an OSS recipient. This rate is intended to cover the full scope of services required to be provided under the community residential care facility licensing requirements established by the South Carolina Department of Health and Environmental Control.

C. Community Residential Care Facility (CRCF) — a facility licensed by the South Carolina Department of Health and Environmental Control as a "Community Residential Care Facility."

D. Net Income Limitation — the maximum monthly countable income which an individual may have in order to qualify for OSS benefits, as such limit (cap) has been established by the South Carolina legislative budgetary process.

E. Countable Income — an individual's gross income less those exclusions of income allowed under the provisions of the federal Supplemental Security Income (SSI) Program.

F. Countable Resources — an individual's available assets as determined under the provisions of the federal Supplemental Security Income (SSI) Program.

G. Supplemental Security Income (SSI) Program — Title XVI of the Social Security Act.

H. Personal Needs Allowance — the specific dollar amount of countable income set by the South Carolina legislative budgetary process that an OSS recipient is allowed to retain for that individual's personal needs.

HISTORY: Added by State Register Volume 24, Issue No. 3, eff March 23, 2001.

126–920. Eligibility.

A. An individual must meet the following requirements in order to be eligible for OSS benefits:

- (1) Be a resident of the State of South Carolina;
- (2) Has been determined by the Social Security Administration (SSA) or by the State in accordance with applicable SSA criteria to be aged, blind, or disabled;
- (3) Has countable resources that do not exceed the eligibility limitations for resources set by the federal Supplemental Security Income (SSI) Program;
- (4) Meets one of the following four conditions with respect to countable income:
 - (a) Receives an SSI payment, which when combined with other countable income gives the individual total countable income that is less than the applicable net income limitation of the OSS Program; or
 - (b) Receives countable income that exceeds the SSI payment standard, but is less than the applicable net income limitation of the OSS Program; or
 - (c) Receives countable income that is less than the SSI payment standard and has applied for SSI benefits; or

- (d) Receives countable income that is less than the SSI payment standard, but has not applied for SSI benefits or has been denied SSI benefits for the sole reason that the community residential care facility in which the applicant resides is considered by the SSI Program to be a public institution;
- (5) Meets all other eligibility criteria to receive benefits under the SSI Program, with the allowable exception of meeting a condition described in (4)(b) or (4)(d) above;
- (6) Resides in a community residential care facility that has executed a "Facility Participation Agreement for the South Carolina Optional State Supplementation (OSS) Program" with the Department of Health and Human Services; AND
- (7) Has applied for all benefits, public or private, to which he or she may be legally entitled.

B. When both members of a couple reside or wish to reside in a community residential care facility and apply for benefits from the OSS Program, the eligibility determination process shall treat both members as individuals beginning in the month of admission to the community residential care facility, even if both members occupy the same room.

C. Under the terms of a contract between the Department of Health and Human Services and the Department of Social Services (DSS), determinations of OSS Program eligibility are conducted by the county DSS offices. An individual seeking OSS benefits must file an application with his or her county DSS office. Changes that might affect the eligibility of an individual or a couple must also be reported to the county Department of Social Services.

D. OSS Program eligibility shall be re-established every twelve (12) months, or more frequently as may be necessary.

E. Changes that might affect the eligibility of an individual or a couple must be reported to the Department of Social Services within ten (10) days of the change. When such a change is reported, a redetermination of eligibility and benefit payments shall be made promptly.

F. The OSS Program is not part of the South Carolina Medicaid Program, but all OSS recipients are eligible for Medicaid because of their participation in the OSS Program.

G. A community residential care facility participating in the OSS Program may not charge an OSS recipient or the recipient's family any additional amount for services included in the OSS facility rate. Failure to adhere to this requirement may subject the OSS recipient to a loss or reduction of OSS benefits and/or a loss of Medicaid eligibility because such additional payment is considered to be additional countable income. The imposition of additional charges for services included in the OSS facility rate also constitutes grounds for termination of the facility's OSS participation.

H. OSS recipients who lose their OSS eligibility as the result of cost-of-living increases in Social Security Title II benefits [Retirement, Survivors, or Disability Insurance (RSDI)] may continue to be eligible for Medicaid through a pass along category of eligibility (Category 16).

HISTORY: Added by State Register Volume 24, Issue No. 3, eff March 23, 2001.

126-930. Termination, Suspension or Reduction of Benefits.

Eligibility for further OSS payments shall be terminated as soon as information indicating ineligibility is reported.

History: Added by State Register Volume 24, Issue No. 3, eff March 23, 2001.

126-940. Program Administration.

A. Subject to the availability of funding, the OSS Program will supplement the income of eligible individuals for whom an OSS slot request has been approved.

B. The Department of Health and Human Services will establish the maximum number of OSS recipients that can be funded with the appropriations made available through the South Carolina legislative budgetary process, and will develop and administer appropriate waiting lists as may be necessary to ensure that the OSS Program is administered within the scope of the available funding.

C. OSS benefits will be paid monthly by the Department of Health and Human Services through the issuance of a single check to each participating community residential care facility that includes the OSS benefit payments for all OSS recipients residing in that facility during the month for which the

payment is being made. This check will be accompanied by a schedule of the individuals covered and the amount of the OSS benefit payment for each individual.

D. Community residential care facilities participating in the OSS Program must maintain adequate records of the OSS benefit payments received by the facility on behalf of each OSS recipient, and the facility must be able to accurately account for its disposition of each resident's funds.

E. Cost-of-living adjustments in benefit payments made by the federal government will result in adjustments in the OSS Program as directed by the South Carolina General Assembly in the legislative budgetary process. In the event that no specific direction is provided for the treatment of a federal cost-of-living adjustment, such adjustment will result in no change to the OSS net income limitation, the OSS facility rate, or the personal needs allowance; OSS benefit payment amounts will be adjusted to reflect the changes in recipients' countable income.

F. Community residential care facilities who choose to participate in the OSS Program are required to comply with the policies and procedures of the OSS Program as may be issued by the Department of Health and Human Services in handbooks, manuals, program bulletins, notices, or regulations. Non-compliance may result in the termination of a facility's OSS participation.

G. A community residential care facility participating in the OSS Program may not charge an OSS recipient or the recipient's family any additional amount for services included in the OSS facility rate. The imposition of additional charges for services included in the OSS facility rate constitutes grounds for termination of the facility's OSS participation.

H. Individuals who seek or receive benefits from the OSS Program are required to comply with the policies and procedures of the OSS Program as may be issued by the Department of Health and Human Services in handbooks, manuals, program bulletins, notices, or regulations. Non-compliance may result in the denial or termination of an individual's eligibility and benefit payments under the OSS Program.

HISTORY: Added by State Register Volume 24, Issue No. 3, eff March 23, 2001.