STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State South Carolina

DEFINITIONS OF CLAIMS FOR TYPE OF SERVICE

The following is a description of the type of claim for service and a definition of a claim for the purpose of meeting the requirements as specified under 42 CFR 447.45:

Claim for Services	Definition of Type Claim
Hospital	Bill for services
Clinics	Bill for services
Physician or Group	Bill for services
Dental	Bill for services
Home Health Agency	Bill for services
Drugs	Line item of services
Durable Medical Equipment	Bill for services
Independent Laboratory & X-Ray	Bill for services
Ambulance Services	Bill for services
Rural Health Clinics	Bill for services
Medical Transportation	Bill for services
CAP Agencies	Bill for services
Opticians, Optometrists, Podiatrists	Bill for services

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Effective Date 1-1-82
RO Approval 5-19-82

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: South Carolina

Requirements for Third Party Liability -
Identifying Liable Resources

1. Date exchanges as required in 433.138(d)(1) with SWICA and the SSA wage and earnings file are performed monthly. Those required in (d)(3) with the State title IV-A agency are performed quarterly. The exchange with Worker's Compensation is not currently performed. Diagnosis and trauma code edits as required in 433.138(e) are performed weekly for all claims approved during the week.

2. Within 30 days of receipt of information regarding employment from SWICA, SSA wage and earnings file, and Title IV-A data exchanges, letters are sent to each identified employer asking if the Medicaid recipient has employment-related health insurance. If no response is received within 30 days a second letter is sent. If the employer's response indicates that insurance exists the information is verified and incorporated into the third party data base and recovery unit within 45 days of receipt as required in 433.138(9)(l)(i).

Health insurance information obtained through the eligibility process is forwarded to this agency from the Department of Social Services. It is manually screened for completeness, verified, and incorporated into the third party data base and recovery unit within 60 days of receipt as required in 433.138(9)(2)(i). No information is obtained from Worker's Compensation.

3. The State motor vehicle accident report file data exchange is not currently performed.

4. Within 10 days of receipt of information regarding claims paid with traumatic diagnosis codes (ICD-9 codes 800 through 999, inclusive) a questionnaire is mailed to each indicated recipient asking how they were injured and requesting information regarding their attorney or liability insurance (if any). If the recipient does not respond within 30 days a second request is mailed. If their response indicates the probable existence of a liable third party, a case file is established and information is entered into the third party data base within 30 days of receipt of the response. On a monthly basis, a report is generated from the data base indicating how many questionnaires were sent for each diagnosis code, how many responses were received, and how many cases were established. This information is analyzed and used to prioritize the cases which are most productive in generating cases. For the most productive codes, if a recipient does not respond to the second questionnaire a third questionnaire is generated; for the least productive codes, only a first questionnaire is generated.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: South Carolina

Requirements for Third Party Liability -
Payment of Claims

The State uses a cost avoidance method of claims processing when third party liability is established at the time a claim is filed. The State Health and Human Services Finance Commission does not utilize a threshold value in the cost avoidance process.

Exceptions to the cost avoidance method are waivered claims (pharmacy and crossover physician claims), EPSDT, prenatal or preventive pediatric care and all claims covered by absent parent maintained insurance under Part D of Title IV of the Act.

1. When a recipient's third party liability is derived from an absent parent whose obligation to pay child support is being enforced by the IV-D agency, providers are not required to bill that third party prior to billing Medicaid. Medicaid pays the claims and receives a report listing all claims paid under these circumstances on a weekly basis. Reimbursement is subsequently sought up to the amount of the Medicaid payment.

2. In general, recovery of reimbursement is sought directly from the liable health insurance companies for all identified claims without regard to a threshold amount or any other guideline. The sole exception is for institutional provider claims paid prior to the onset of cost avoidance where other health insurance resources are known to exist. Because recovery of reimbursement for these claims is sought directly from the providers rather than from the liable health insurance companies it is not cost effective to pursue claims with small dollar amounts. For these claims only, a threshold amount of $20 per claim is utilized in the pay and chase process.

For discovery of Casualty Recovery cases, a minimum threshold of one paid claim of at least $250 will be established. For cases discovered through other means, the Department will accumulate paid claims until the threshold of $250 has been reached, at which point a Casualty Recovery claim will be established. For all claims established, the Department shall assert for full reimbursement of the Medicaid Claim from known liable parties. Upon discovery and establishment of a claim, and at all times during the pursuit of recovery of the claim, the department shall determine what portion of the gross settlement to claim based on cost effectiveness. For cases where the potential settlement proceeds available are less than twice the amount of Medicaid Paid Claims, the Department will determine what portion of the total recovery to pursue based upon cost effectiveness principles.

The Department's review of cost effectiveness shall include, but not be limited to, documentation as to the Factual and Legal issues of certainty of liability; the department's previous professional experience with the recipient's Counsel and related Jurisdiction; the involvement of multiple third parties, COB, and other payment sources (ie.. PIP, Worker's Comp, Underinsured Motorist, Uninsured Motorist), the estimated attorney's fees, and any other cost of recovery.

The Department will at all times pursue that amount which will maximize total net recoveries to the program. When deemed appropriate, the Department will attempt to resolve the case through binding arbitration, arbitration or mediation. The Department will not agree to a lesser recovery amount than that determined by an analysis of cost-effectiveness.

In all instances, the Department, through the assignment of rights to third party benefits as a condition of eligibility, reserves the right to pursue known liable third parties on behalf of the Recipient. In instances where it has been determined that the Recipient has engaged sufficient competent representation, and is in pursuit of known liable third parties, the Department may rely upon their services and seek reimbursement of Medicaid Paid Claims from the obtain settlement proceeds.

The Department shall apply available resources in a manner that ensures maximum average return over the entire caseload, and will apply the cost effectiveness principle established in 1902(a)(25)(B)in determining the amount of recovery to pursue based on the likelihood of collections.

3. All claims which are not cost-avoided, including waivered claims (pharmacy and crossover physician claims), EPSDT, prenatal or preventative pediatric care, and all claims covered by absent parent maintained insurance under Part D of Title IV of the Act, are accumulated and billed directly to the liable health insurance companies on a quarterly basis without regard to a dollar amount.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: South Carolina

Citation	Condition or Requirement
1906 of the Act	State Method on Cost Effectiveness of Employer Based Group Health Plans

I. The State of South Carolina uses the following methods to determine the cost effectiveness of paying group health insurance premiums for Medicaid clients:

1) Cost Effectiveness Based on Client Diagnosis
The determination of cost effectiveness is based on the comparison of premium amounts and the policyholder obligations against the anticipated expenditures identified with a diagnosis that will require long term treatment. Such a diagnosis would include cancer, chronic heart disease, congenital heart disease, and stage renal disease, and AIDS. This list will be expanded as diagnoses associated with anticipated with long term care are targeted. This method of determination is also appropriate for short term high expense treatments such as pregnancy. A client's case is considered as cost effective when anticipated expenditures associated with the diagnosis exceed the premium amounts and policyholder obligations as the condition is likely to continue.

2) Cost Effectiveness Based on Actual Expenditures
The determination of cost effectiveness is based on the comparison of premium amounts and policyholder obligations against the actual claims experience for the client. Documentation of actual expenditures consists of Explanation of Benefits (EOB's) from the client's health carrier for previous charges or Medicaid expenditures for previous periods of the client's eligibility. A client's case is determined as cost effective if actual claim expenditures exceed premium amounts and policyholder obligations.

3) Cost Effectiveness Based on Expenditure Projection
The determination of cost effectiveness is based on the comparison of the amount of the annual premium, deductibles, coinsurance, policyholder cost sharing obligations, and additional administrative costs against the average annual cost of Medicaid expenditures for the recipient's eligibility classification for types of services covered under a group plan. The Medicaid Management Information System (MMIS) is utilized to obtain the

average annual Medicaid cost of a recipient by age, sex, qualifying category and geographical location. A client's case is determined as cost effective if the amount of the premium, deductibles, coinsurance, cost sharing obligation, and administrative costs are less than the Medicaid expenditures for an equivalent set of services.

II. Because Federal Financial Participation (FFP) is available for the Payment of premiums for Medicaid recipients enrolled in a cost effective group health plan:

1) Medicaid will pay the health insurance premiums (policyholder portion only if an employment related policy) for Medicaid recipients with policies likely to be cost effective to the Medicaid program. Payments shall be made directly to the insurer providing the coverage, the employer or to the Medicaid recipient or guardian.

2) Medicaid will pay the Medicaid allowable amount for all items and services provided the Medicaid recipient under the state plan that are not covered under the group health plan.

3) Medicaid will provide for the payment of premiums when cost effective for non-Medicaid eligible family members in order to enroll a Medicaid eligible family member in the group health plan.

4) Medicaid will treat the group health plan as a third party resource in accordance with South Carolina Medicaid TPL cost avoidance policies.

5) The health carrier, employer, recipient or non-Medicaid eligible family member will immediately notify this agency of any event that might affect the policyholder status or the cost effectiveness of the health insurance policy.

6) Medicaid will receive referrals for potential candidates for the payment of premiums. Referral systems have been established through the South Carolina Hospital Association and the South Carolina Physician Association, state-wide and community based AIDS support groups, agency Community Long Term Care (CLTC) area offices and internally generated reports.

State: South Carolina

Citation	Sanctions for MCOs and PCCMs
1932(e) 42 CFR 428.726	(a) The State will monitor for violations that involve the actions and failure to act specified in 42 CFR Part 438 Subpart I and to implement the provisions in 42 CFR 438 Subpart I, in manner specified below:
	(b) The State uses the definition below of the threshold that would be met before an MCO is considered to have repeatedly committed violations of section 1903(m) and thus subject to imposition of temporary management:
	(c) The State's contracts with MCOs provide that payments provided for under the contract will be denied for new enrollees when, and for so long as, payment for those enrollees is denied by CMS under 42 CFR 438.703(e).
	____ Not applicable; the State does not contract with MCOs, or the State does not choose to impose intermediate sanctions on PCCMs.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: South Carolina

INCOME AND ELIGIBILITY VERIFICATION SYSTEM PROCEDURES
REQUESTS TO OTHER STATE AGENCIES

South Carolina State Retirement System Match:

Active Medical Assistance Only cases are matched with the State Retirement System file. The match is accomplished twice a year. The match provides documentation of benefit amount. When the match is completed a report is forwarded to the caseworker who verifies that the income and state retirement insurance on the report coincides with that in the case record. If discrepancies are identified, they re resolved and corrections made to the case.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: South Carolina

METHOD FOR ISSUANCE OF MEDICAID ELIGIBILITY CARDS
TO HOMELESS INDIVIDUALS

Medicaid Cards are made available to homeless individuals in any of the following ways:

1. They may be mailed to the address where the recipient routinely receives his mail; or

2. They may be mailed to a post office box or to General Delivery at a specific post office where the recipient routinely receives his mail; or

3. They may be mailed to the County Department of Social Services for the recipient to pick up at his convenience.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: South Carolina

REQUIREMENTS FOR ADVANCE DIRECTIVES UNDER STATE PLANS
FOR MEDICAL ASSISTANCE

The following is a written description of the law of the State (whether statutory or as recognized by the courts of the State) concerning advance directives. If applicable, State should include definitions of living will, durable power of attorney for health care, durable power of attorney, witness requirements, special State limitations on living will declarations, proxy designation, process information and State forms, and identify whether State law allows for a health care provider or agent of the provider to object to the implementation of advance directives on the basis of conscience.

SEE ATTACHMENT

YOUR RIGHT TO MAKE DECISIONS ABOUT YOUR HEALTH CARE

You Have the Right to Make Health Care Decisions that Affect you

You have the right to make all decisions about the health care you receive. If you do not want certain treatments, you can tell your doctor, either in person or in writing, that you do not want them. If you want to refuse treatment but you do not have someone to name as your agent, you can sign a living will.

Most patients can express their wishes to their doctor, but some who are badly injured, unconscious, or very ill cannot. People need to know your wishes about health care in case you become unable to speak effectively for yourself. You can express your wishes in a health care power of attorney or a living will.

In a living will you can tell your doctor that you do not want to receive certain treatment. In a health care power of attorney you name an agent who will tell the doctor what treatment should or should not be provided.

The decision to sign a health care power of attorney or living will is very personal and very important. This pamphlet answers some frequently asked questions about health care powers of attorney and living wills.

These documents will be followed only if you are unable, due to illness or injury, to make decisions for yourself. While you are pregnant, however, these documents will not cause life support to be withheld.

If you do not have a living will or health care power of attorney that tells what you want done, you do not know what decisions will be made or who will make them. Decisions may be made by certain relatives designated by South Carolina law, by a person appointed by the court, or by the court itself. The best way to make sure <u>your</u> wishes are followed is to state your wishes in a health care power of attorney, or sometimes, a living will. If you want to refuse treatment but you do not have someone to name as your agent, you can sign a living will.

If you have questions about signing a health care power of attorney or living will, you should talk to your doctor; your minister, priest, rabbi, or other religious counselor; or your attorney. Finally, it is <u>very</u> important that you discuss your feelings about life support with your family. A health care power of attorney also should be discussed with the people you intend to name as your agent and alternate agents to make sure that they are willing to serve. It is also important to make sure that your agents know your wishes.

<u>Are there forms for living wills and health care powers of attorney in South Carolina?</u>

Yes. The South Carolina legislature has approved forms for both a living will and a health care power of attorney. The living will form that the

Legislature approved is called a "Declaration of a Desire for a Natural Death." You may be able to get these forms from the person who gave you this brochure. If not, you may call:

Your local Council on Aging	1 (800) 868-9095
South Carolina Commission on Aging	(803) 734-2995
Joint Legislative Committee on Aging	(803) 734-0457

How are a Health Care Power of Attorney and a Living Will different?

- The agent named in a health care power of attorney can make all of the decisions about your health care that need to be made. A living will affects only life support.

- A living will affects life support only in certain circumstances. A living will only tells the doctor what to do if you are permanently unconscious or if you are terminally ill and close to death. A health care power of attorney is not limited to these situations.

  "Permanently unconscious" means that you are in a persistent vegetative state in which your body functions but your mind does not. This is different from a coma, because a person in a coma usually wakes up, but a permanently unconscious person does not.

- A living will can only say what treatment you don't want. In a health care power of attorney you can say what treatment you do want as well as what you do not want.

- With a living will, you must decide what should be done in the future, without knowing exactly what the circumstances will be when the decision is put into effect. With a health care power of attorney, the agent can make decisions when the need arises, and will know what the circumstances are.

- An Ombudsman from the Governor's Office must be a witness if you sign a living will when you are in a hospital or nursing home. An Ombudsman does not have to be a witness if you sign a health care power of attorney in a hospital or nursing home.

I want to be allowed to die a natural death and not be kept alive by medical treatment, heroic measures, or artificial means. How can I make sure this happens?

The best way to be sure you are allowed to die a natural death is to sign a health care power of attorney that states the circumstances in which you would not want treatment. In the South Carolina form, you should specify your wishes in Items 6 and 7.

You may not have a person that you can trust to carry out your desire for a natural death. If not, a living will can ensure that you are allowed to die a natural death. However, it will only do so if you are permanently unconscious or terminally ill and close to death.

Which document should I sign if I want to be treated with all available life-sustaining procedures?

You should sign a Health Care Power Of Attorney, and not a living will. The South Carolina Health Care Power of Attorney form allows you to say either that you do or that you do not want life-sustaining treatment. A living will only allows you to say that you do not want life-sustaining procedures.

What if I have an old health care power of attorney or living will, or signed one in another state?

If you previously signed a living will or health care power of attorney, even in another state, it is probably valid. However, it may be a good idea to sign the most current forms. For example, the current South Carolina living will form covers artificial nutrition and hydration whereas older forms did not.

How is a health care power of attorney different from a durable power of attorney?

A health care power of attorney is a specific type of durable power of attorney that names an agent only to make health care decisions.

A durable power of attorney may or may not allow the agent to make health care decisions. It depends on what the document says. The agent may only be able to make decisions about property and financial matters.

What are the requirements for signing a living will?

You must be eighteen years old to sign a living will. Two persons must witness your signing the living will form. A notary public must also sign the living will. If you sign a living will while you are a patient in a hospital or a resident in a nursing home, a representative from the Governor's Office (the Ombudsman) must witness your signing.

There are certain people who cannot witness your living will. The living will form says who cannot be a witness. You should read the living will form carefully to be sure your witnesses are qualified.

What are the requirements for signing a health care power of attorney?

You must have two witnesses sign the document. The form tells you who cannot be witnesses. (These are the same people who cannot witness a living will.) Unlike a living will, the health care power of attorney may be signed in a hospital or

in a nursing home without having someone from the Ombudsman's Office present. It is not necessary to have a notary sign your health care power of attorney.

Whom should I appoint as my agent? What if my agent cannot serve?

You should appoint a person you trust and who knows how you feel about health care. You also should name at least one alternate, who will make decisions if your agent is unable or unwilling to make these decisions. You should talk to the people you choose as your agent and alternate agents to be sure they are willing to serve. Also, they should know how you feel about health care.

Is there anything I need to know about completing the living will or health care power of attorney form?

Each form contains spaces for you to state your wishes about things like whether you want life support and tube feeding. If you do not put your initials in either blank, tube feeding may be provided, depending upon your condition. Be sure to read the forms carefully and follow the instructions.

Where should I keep my health care power of attorney or living will?

Keep the original in a safe place where your family members can get it. You also should give a copy to as many of the following people as you are comfortable with: your family members, your doctor, your lawyer, your minister or priest, or your agent. Do not put your only copy of these documents in your safe deposit box.

What if I change my mind after I have signed a living will or health care power of attorney?

You may revoke (cancel) your living will or health care power of attorney any time. The forms contain instructions for doing so. You must tell your doctor and anyone else who has a copy that you have changed your mind and you want to revoke your living will or health care power of attorney.

Your patients may ask you for a sample form of the advance directives like the Durable Power of Attorney for Health Care and the Declaration of a Desire for a Natural Death. Attached to this Medicaid Bulletin are copies of the statutory forms. If you decide to provide your patients with forms for advance directives, it is suggested that providers use copies of these specific forms. Doctors and other health care providers recognize these forms and do not have to question the validity of other forms which may or may not comply with state law. There are also certain statutory protections which are provided to health care providers and hospitals by the statute. Use of the statutory form Durable Power Of Attorney for Health Care and Declaration of Desire for Natural Death will insure that these protections are available to the health care provider.

SC: MA 93-001
EFFECTIVE DATE: 1/01/93
RO APPROVAL: 3/22/93
SUPERSEDES: MA 91-19

HEALTH CARE POWER OF ATTORNEY
(South Carolina Statutory Form, Code of Laws Section 62-5-504)

1. DESIGNATION OF HEALTH CARE AGENT

I, _____, hereby appoint
(Principal)

_____
(Agent)

_____
(Address)

_____

Home Telephone: _____ Work Telephone: _____ as my agent to make health care decisions for me as authorized in this document.

2. EFFECTIVE DATE AND DURABILITY
By this document I intend to create a durable power of attorney effective upon, and only during, any period of mental incompetence.

3. AGENT'S POWERS
I grant to my agent full authority to make decisions for me regarding my health care. In exercising this authority, my agent shall follow my desires as stated in this document or otherwise expressed by me or known to my agent. In making any decision, my agent shall attempt to discuss the proposed decision with me to determine my desires if I am able to communicate in any way. If my agent cannot determine the choice I would want made, then my agent shall make a choice for me based upon what my agent believes to be in my best interests. My agent's authority to interpret my desire is intended to be as broad as possible, except for any limitations I may state below.

Accordingly, unless specifically limited by Section E, below, my agent is authorized as follows:

A. To consent, refuse, or withdraw consent to any and all types of medical care, treatment, surgical procedures, diagnostic procedures, medication, and the use of mechanical or other procedures that affect any bodily function, including, but not limited to, artificial respiration, nutritional support and hydration and cardiopulmonary resuscitation;

B. To authorize, or refuse to authorize, any medication or procedure intended to relieve pain, even though such use may lead to physical damage, addiction, or hasten the moment of, but not intentionally cause, my death;

C. To authorize my admission to or discharge, even against medical advice, from any hospital, nursing care facility, or similar facility or service;

D. To take any other action necessary to making, documenting, and assuring implementation of decisions concerning my health care, including, but not limited to granting any waiver or release from liability required by any hospital, physician, nursing care provider, or other health care provider; signing any documents relating to refusals of treatment or the leaving of a facility against medical advice, and pursuing any legal action in my name, and at the expense of my estate to force compliance with my wishes as determined by my agent, or to seek actual or punitive damages for the failure to comply.

E. The powers granted above do not include the following powers or are subject to the following rules or limitations: _____

_____

_____

_____

4. ORGAN DONATION (INITIAL ONLY ONE)
My agent may _____; may not_____ consent to the donation of all or any of my tissue or organs for purposes of transplantation.

5. EFFECT ON DECLARATION OF A DESIRE FOR A NATURAL DEATH (LIVING WILL)
I understand that if I have a valid Declaration of a Desire for a Natural Death, the instructions contained in the Declaration will be given effect in any situation to which they are applicable. My agent will have authority to make decisions concerning my health care only in situations to which the Declaration does not apply.

6. STATEMENT OF DESIRES AND SPECIAL PROVISIONS
With respect to any Life-Sustaining Treatment, I direct the following: (INITIAL ONLY ONE OF THE FOLLOWING 4 PARAGRAPHS)

(1)_____ GRANT OF DISCREATION TO AGENT. I do not want my life to be prolonged nor do I want life-sustaining treatment to be provided or continued if my agent believes the burdens of the treatment outweigh the expected benefits. I want my agent to consider the relief of suffering, my personal beliefs, the expense involved and the quality as well as the possible extension of my life in making decisions concerning life-sustaining treatment.

OR

(2)_____DIRECTIVE TO WITHHOLD OR WITHDRAW TREATMENT. I do not want my life to be prolonged and I do not want life-sustaining treatment:

a. If I have a condition that is incurable or irreversible and, without the administration of life-sustaining procedures, expected to result in death within a relatively short period of time: or
b. if I am in a state of permanent unconsciousness.

OR

(3)_____DIRECTIVE FOR MAXIMUM TREATMENT. I want my life to be prolonged to the greatest extent possible, within the standards of accepted medical practice, without regard to my condition, the chances I have for recovery, or the cost of the procedures.

OR

(4)_____DIRECTIVE IN MY OWN WORDS:_____

_____

_____

_____

_____

7. STATEMENT OF DESIRES REGARDING TUBE FEEDING
With respect to Nutrition and Hydration provided by means of a nasogastric tube or tube into the stomach, intestines, or veins, I wish to make clear that: (INITIAL ONLY ONE)

_____I do not want to receive these forms of artificial nutrition and hydration, and they may be withheld or withdrawn under the conditions given above.

OR

_____I do want to receive these forms of artificial nutrition and hydration.

IF YOU DO NOT INITIAL EITHER OF THE ABOVE STATEMENTS, YOUR AGENT WILL NOT HAVE AUTHORITY TO DIRECT THAT NUTRITION AND HYDRATION NECESSARY FOR COMFORT CARE OR ALLEVIATION OF PAIN BE WITHDRAWN.

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SUPERSEDES: N/A

8. SUCCESSORS

If an agent named by me dies, becomes legally disabled, resigns, refuses to act, becomes unavailable, or if an agent who is my spouse is divorced or separated from me, I name the following successors to my agent, each to act alone and successively, in order named.

A. First Alternate Agent:_____

Address:_____

_____Telephone:_____

B. Second Alternate Agent: _____

Address:_____

_____Telephone:_____

9. ADMINISTRATIVE PROVISIONS

a. I revoke any prior Health Care Power of Attorney and any provisions relating to health care of any other prior power of attorney.

b. This power of attorney is intended to be valid in any jurisdiction in which it is presented.

10. UNAVAILABILITY OF AGENT

If at any relevant time the Agent or Successor Agents named herein are unable or unwilling To make decisions concerning my health care, and those decisions are to be made by a guardian, by the Probate Court, or by a surrogate pursuant to the Adult Health Care Consent Act, it is my intention that the guardian, Probate Court, or surrogate make those decisions in accordance with my directions as stated in this document.

BY SIGNING HERE, I INDICATE THAT I UNDERSTAND THE CONTENTS OF THIS DOCUMENT AND THE EFFECT OF THIS GRANT OF POWERS TO MY AGENT.

I sign my name to this Health Care Power of Attorney on this ____ day of_____ 20____. My current home address is:_____

_____

Signature:_____

Print Name:_____

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SUPERSEDES: N/A

WITNESS STATEMENT

I declare, on the basis of information and belief that the person who signed or acknowledged this document (the principal) is personally known to me, that he/she signed or acknowledged this Health Care Power of Attorney in my presence, and that he/she appears to be of sound mind and under no duress, or undue influence.

I am not related to the principal by blood, marriage, or adoption, either as a spouse, a lineal ancestor, descendant of the parents of the principal, or spouse of any of them. I am not directly financially responsible for the principal's medical care. I am not entitled to any portion of the principal's estate upon his/her decease, whether under any will or as an heir by intestate succession, nor am I the beneficiary of an insurance policy on the principal's life, nor do I have a claim against the principal's estate as of this time. I am not the principal's attending physician, nor an employee of the attending physician. No more than one witness is an employee of a health facility in which the principal is a patient. I am not appointed as Health Care Agent or Successor Health Care Agent by this document.

Witness no. 1:

Signature:_____Date:_____

Print Name:_____Telephone:_____

Residence Address:_____

_____

Witness No. 2:

Signature:_____Date:_____

Print Name:_____Telephone:_____

Residence Address:_____

_____

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SUPERSEDES: N/A

DECLARATION OF A DESIRE FOR A NATURAL DEATH

STATE OF SOUTH CAROLINA

COUNTY OF_____

I,_____Declarant, being at least eighteen years of age and a resident of and domiciled in the City of _____County of _____ State of South Carolina, make this Declaration this day of _____20_____.

I willfully and voluntarily make known my desire that no life-sustaining procedures be used to prolong my dying if my condition is terminal or if I am in a state of unconsciousness, and I declare:

If at any time I have a condition certified to be a terminal condition by two physicians who have personally examined me, one of whom is my attending physician, and the physicians have determined that my death could occur within a reasonably short period of time without the use of life-sustaining procedures or if the physicians certify that I am in a state of permanent unconsciousness and where the application of life-sustaining procedures would serve only to prolong the dying process, I direct that the procedures be withheld or withdrawn, and that I be permitted to die naturally and with only the administration of medication or the performance of any medical procedure necessary to provide me with comfort care.

INSTRUCTIONS CONCERNING ARTIFICIAL NUTRITION AND HYDRATION

INITIAL ONE OF THE FOLLOWING STATEMENTS

If my condition is terminal and could result in death within a reasonably short time,

_____ I direct that nutrition and hydration BE PROVIDED through any medically indicated means, including medically or surgically implanted tubes.

_____ I direct that nutrition and hydration NOT BE PROVIDED through any medically indicated means, including medically or surgically implanted tubes.

INITIAL ONE OF THE FOLLOWING STATEMENTS

If I am in a persistent vegetative state or other condition of permanent unconsciousness,

_____ I direct that nutrition and hydration BE PROVIDED through any medically indicated means, including medically or surgically implanted tubes.

_____ I direct that nutrition and hydration NOT BE PROVIDED through any medically indicated means, including medically or surgically implanted tubes.

In the absence of my ability to give directions regarding the use of life-sustaining procedures, it is my intention that this Declaration be honored by my family and physicians and any health facility in which I may be a patient as the final expression of my legal right to refuse medical or surgical treatment, and I accept the consequences from the refusal.

I am aware that this Declaration authorizes a physician to withhold or withdraw life-sustaining procedures, I am emotionally and mentally competent to make this Declaration.

APPOINTMENT OF AN AGENT (OPTIONAL)

1. You may give another person authority to revoke this Declaration on your behalf. If you wish to do so, please enter that person’s name in the space below.

Name of Agent with Power to Revoke:_____

Address:_____

Telephone Number:_____

2. You may give another person authority to enforce this Declaration on your behalf. If you wish to do so, please enter that person’s name in the space below.

Name of Agent with Power to Enforce:_____

Address:_____

Telephone Number:_____

REVOCATION PROCEDURES

THIS DECLARATION MAY BE REVOKED BY ANY ONE OF THE FOLLOWING METHODS. HOWEVER, A REVOCATION IS NOT EFFECTIVE UNTIL IT IS COMMMUNICATED TO THE ATTENDING PHYSICIAN:

(1) BY BEING DEFACED, TORN, OBLITERATED, OR OTHERWISE DESTROYED, TORN, OBLITERATED, OR OTHERWISE DESTROYED IN EXPRESSION OF YOUR INTENT TO EVOKE BY YOU OR BY SOME PERSON IN YOUR PRESENCE AND BY YOUR DIRECTION. REVOCATION BY DESTRUCTION OF ONE OR MORE OF MULTIPLE ORIGINAL DECLARATIONS REVOKES ALL OF THE ORIGINAL DECLARATIONS.

(2) BY A WRITTEN REVOCATION SIGNED AND DATED BY YOU EXPRESSING YOUR INTENT TO REVOKE.

(3) BY YOUR ORAL EXPRESSION OF YOUR INTENT TO REVOKE THIS DECLARATION. AN ORAL REVOCATION COMMUNICATED TO THE ATTENDING PHYSICIAN BY A PERSON OTHER THAN YOU IS EFFECTIVE ONLY IF:

(A) THE PERSON WAS PRESENT WHEN THE ORAL REVOCATION WAS MADE.

(B) THE REVOCATION WAS COMMUNICATED TO THE PHYSICIAN WITHIN A REASONABLE TIME.

(C) YOUR PHYSICAL OR MENTAL CONDITION MAKES IT IMPOSSIBLE FOR THE PHYSICIAN TO CONFIRM THROUGH SUBSEQUENT CONVERSATION WITH YOU THAT THE REVOCATION HAS OCCURRED.

TO BE EFFECTIVE AS A REVOCATION, THE ORAL EXPRESSION CLEARLY MUST INDICATE YOUR DESIRE THAT THE DECLARATION NOT BE GIVEN EFFECT OR THAT LIFE-SUSTAINING PROCEDURES BE ADMINISTERED:

(4) IF YOU, IN THE SPACE ABOVE, HAVE AUTHORIZED AN AGENT TO REVOKE THE DECLARATION, THE AGENT MAY REVOKE ORALLY OR BY A WRITTEN, SIGNED, AND DATED INSTRUMENT. AN AGENT MAY REVOKE ONLY IF YOU ARE INCOMPETENT TO DO SO. AN AGENT MAY REVOKE THE DECLARATION PERMANENTLY OR TEMPORARILY.

(5) BY YOUR EXECUTING ANOTHER DECLARATION AT A LATER TIME.

_____
Signature of Declarant

AFFIDAVIT

STATE OF_____

COUNTY OF_____

We,_____ **and** _____ **the undersigned witness to the foregoing Declaration dated the** _____ **day of** _____ **20**____ **at least one of us being first duly sworn, declare to the undersigned authority, on the basis of our best information and belief, that the Declaration was on that date signed by the declarant as and his DECLARATION OF A DESIRE FOR A NATURAL DEATH in our presence and we, at this request and this presence and in the presence of each other, subscribe our names as witnesses on that date. The declarant is personally known to us, and we believe him to be of sound mind. Each of us affirms that he is qualified as a witness to this Declaration under the provisions of the South Carolina Death With Dignity Act in that he is not related to the declarant by blood, marriage, or adoption, either as spouse, lineal ancestor, descendant of the parents or declarant, or spouse of any of them; not directly financially responsible for the declarant's medical care; not entitled to any portion of the declarant's estate upon his decease, whether any will or as an heir by intestate succession; nor the beneficiary of a life insurance policy of the declarant nor the declarant's attending physician; nor an employee of the attendant's physician; nor a person who has a claim against the declarant's decedent's estate as of this time. No more than one of us is an employee of a health facility in which the declarant is a patient. If the declarant is a resident in a hospital or nursing care facility at the date of execution of this Declaration, at least one of us is an ombudsman designated by the State Ombudsman, Office of the Governor.**

_____
Witness

_____
Witness

Subscribed before me by_____**, the declarant and subscribed and sworn before me by** _____**, the witness this** ____**day of** _____**,20**_____**.**

Notary's Signature_____

Notary Public for _____

My Commission Expires_____

SEAL

SC: MA 93-001
EFFECTIVE DATE: 1/01/93
RO APPROVAL: 3/22/93
SUPERSEDES: N/A

Revision: HCFA-PM-95-4 (HSQB)
JUNE 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: South Carolina

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

The State uses other factors described below to determine the seriousness of deficiencies in addition to those described at §488.404(b)(1):

(NOT APPLICABLE)

Revision: HCFA-PM-95-4 (HSQB)
JUNE 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: South Carolina

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Termination of Provider Agreement: Describe the criteria (as required at §1919(h)(2)(A) for applying the remedy.

__X__ Specified Remedy

(Will use the criteria and
notice requirements specified
in the regulation.

Revision: HCFA-PM-95-4 (HSQB)
JUNE 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: South Carolina

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Temporary Management: Describe the criteria (as required at §1919(h)(2)(A) for applying the remedy.

__X__ Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

____Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

Revision: HCFA-PM-95-4 (HSQB)
JUNE 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: South Carolina

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Denial of Payment for New Admissions: Describe the criteria (as required at §1919(h)(2)(A) for applying the remedy.

__X__ Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

____ Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

Revision: HCFA-PM-95-4 (HSQB)
JUNE 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: South Carolina

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Civil Money Penalty: Describe the criteria (as required at §1919(h)(2)(A) for applying the remedy.

__X__ Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

____ Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

Revision: HCFA-PM-95-4 (HSQB)
JUNE 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: South Carolina

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

State Monitoring: Describe the criteria (as required at §1919(h)(2)(A) for applying the remedy.

__X__ Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

____ Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

Revision: HCFA-PM-95-4 (HSQB)
JUNE 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: South Carolina

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Transferring of residents; Transfer of residents with closure of facility:
Describe the criteria (as required at §1919(h)(2)(A) for applying the remedy.

__X__ Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

____ Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

Revision: HCFA-PM-95-4 (HSQB)
JUNE 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: South Carolina

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Additional Remedies: Describe the criteria (as required at §1919(h)(2)(A) for applying the additional remedy. Include the enforcement category in which the remedy will be imposed (i.e., category 1, category 2, or category 3 as described at 42 CFR 488.408).

(NOT APPLICABLE)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: South Carolina

DISCLOSURE OF ADDITIONAL REGISTRY INFORMATION

- Method of Certification e.g. waiver, competency, evaluation, reciprocity
- Last employer (from employment history), if requested

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: South Carolina

COLLECTION OF ADDITIONAL REGISTRY INFORMATION

- Method of Certification e.g. waiver, competency evaluation, reciprocity
- Employment history since May, 1990

* U.S. Government Printing Office

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: South Carolina

DEFINITION OF SPECIALIZED SERVICES

For mental illness, specialized services are those services which combined with services provided by the NF results in the continuous and aggressive implementation of an individualized plan of care that-

i) is developed and supervised by an interdisciplinary team, which includes a physician, qualified mental health professionals and as appropriate, other professionals;

ii) prescribes specific therapies and activities for the treatment of persons experiencing an acute episode of serious mental illness, which necessitates supervision by trained mental health personnel; and

iii) is directed toward diagnosing and reducing the resident's behavioral symptoms that necessitated institutionalization, improving his or her level of independent functioning, and achieving a functioning level that permits reduction in the intensity of mental health services to below the level of specialized services at the earliest possible time.

South Carolina elects not to provide specific examples of these services at this time.

For mental retardation, specialized services are the services specified by the State which, combined with services provided by the NF or other service providers, results in the implementation of an individualized plan of care that-

i) provides specialized and generic training, treatment, health services and related services that is directed toward;

ii) acquiring the behaviors necessary for the client to function with as much self-determination and independence as possible; and

iii) preventing or decelerating regression or loss of current optimal functional status.

South Carolina elects not to provide specific examples of these services at this time.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: South Carolina

CATEGORICAL DETERMINATIONS

Advance categorical determinations that specialized services are not needed are listed below.

a) The individual is being admitted to the nursing facility on a provisional basis for a period not to exceed 14 days to provide respite for in-home caregivers. The anticipated length of stay nullifies the effectiveness of the development and implementation of a plan of specialized services. (MR or MI).

b) The individual is being admitted to the nursing facility on a provisional basis not to exceed 7 days while alternative arrangements can be made. The admission must be at the request of the south Carolina Department of Social Services, Division of Protective Services due to a suspicion of abuse or neglect. This admission is provided on an emergency basis. The anticipated length of stay nullifies the effectiveness of a plan of specialized services. (MR or MI).

c) The individual is being admitted directly to the nursing facility from an acute inpatient setting for a period not to exceed 30 days. The admission must be necessary for treatment of the same condition that necessitated the hospitalization which may not be for treatment of a psychiatric disorder. The anticipated length of stay nullifies the effectiveness of a plan of specialized services. (MR or MI).

d) The individual has been diagnosed as having dementia concurrent with an MR diagnosis. The dementia must be substantiated by the Mini Mental State Exam. (MR only)

Advance categorical determination that nursing facility services are required is as follows.

a) The individual meets the medical eligibility criteria for Medicaid payment to a nursing facility. (MR or MI).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: South Carolina

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Survey and Certification Education Program

The State has in effect the following survey and certification periodic educational program for the staff and residents (and their representatives) of nursing facilities in order to present current regulations, procedures, and policies.

The State will provide regional workshops as required with the advent of new regulations and significant questions of current regulations.

Survey teams will educate residents of nursing facilities during annual recertifications, follow-ups, etc. and at the request of the residents and staff or providers.

The Survey and Certification agency will respond to professional group's in-service request with surveyor staff presenters as schedule permits.

The Survey and Certification agency will continue its affiliation with provider groups in order to identify problem areas and address with appropriate in-service questions.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: South Carolina

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Process for the Investigation of Allegations of Resident Neglect and Abuse and Misappropriation of Resident Property

The State has in effect the following process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property by a nurse aide or a resident in a nursing facility or by another individual used by the facility in providing services to such a resident.

The Division of Certification within the Bureau of Survey and Certification Department of Health and Environmental Control, investigates all allegations against nurse aides of neglect and abuse and misappropriation of resident property by a nurse aide or a resident in a nursing facility or by another individual used by the facility in providing services to such a resident.

These investigations may be completed in conjunction with, but not limited to, entities such as the State Ombudsman Office and the Division of Licensing, Department of Health and Environmental Control.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: South Carolina

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Procedures for Scheduling and conduct of Standard Surveys

The State has in effect the following procedures for the scheduling and conduct of standard surveys to assure that it has taken all reasonable steps to avoid giving notice.

It is the policy of the S.C. State Survey and Certification Agency to have unannounced surveys for all providers and suppliers (other than hospitals), except as indicated. While the unannounced surveys may result in some minor survey problems, this policy represents changing public attitudes and expectations toward compliance surveys.

Exception: Non-long term care facilities other than laboratories and home health agencies may be given advance notice (usually no more than 2 working days before an impending survey) if the following two criteria are met.

The facility is inaccessible via conventional travel means and it is necessary to make special or extraordinary travel arrangements; and -

There is a high probability that the staff essential to the survey process will be absent or the facility will be closed unless the survey is announced.

Monthly schedules are prepared by the program manager and maintained in a secured location. The week's survey schedule is reviewed with survey staff at the beginning of each week. Staff have a signed statements in their personnel folders which indicates the policy of unannounced visits has been reviewed with them as well as the disciplinary action to be taken should they not abide by the agency's policy.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: South Carolina

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Programs to Measure and Reduce Inconsistency

The State has in effect the following programs to measure and reduce inconsistency in the application of survey results among surveyors.

The State has in effect the following programs to measure and reduce inconsistency in the application of survey results among surveyors.

The State Survey Agency has a six month orientation process for new surveyors. The process utilizes a preceptor to direct new staff in the survey process and insure uniformity. Each surveyor attends Basic Surveyor Training provided by HCFA. Staff is surveyed to determine what their in service needs might be and appropriate programs presented based on identified needs. All State Survey Agency Surveyors attend the annual training conference of HCFA Region IV. Surveyor findings in health facilities are reviewed by Program Managers to determine consistency, validity of scope and severity, etc. prior to provider receiving the Statement of Deficiency. Surveyors receive feedback from the Program Managers to assure that problems don’t continue.

Validation surveys by HCFA Region IV Federal surveyors are utilized as training tools to teach application of the survey process, interpretation of findings and as a comparative analysis with the State Agency Survey.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: South Carolina

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Process for Investigations and complaints and Monitoring

The State has in effect the following process for investigating complaints of violations of requirements by nursing facilities and monitors onsite on a regular, as needed basis, a nursing facility's compliance with the requirements of subsection (b), (c), and (d) for the following reasons:

(i) the facility has been found not to be in compliance with such requirements and is in the process of correcting deficiencies to achieve such compliance;

(ii) the facility was previously found not to be in compliance with requirements and has corrected deficiencies to achieve such compliance, and verification of continued compliance is indicated; or

(iii) the State has reason to question the compliance of the facility with such requirements.

At any point in time the state survey agency can initiate the survey process, i.e.

i) deficiencies cited related to complaints are monitored through follow-up surveys

ii) the state survey agency can do interim surveys should verification of continued compliance be warranted.

iii) again interim surveys can be conducted.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: SOUTH CAROLINA

4.42-A Employee Education About False Claims Recoveries.

The Medicaid agency shall assure compliance with section 1902(a)(68) of the Act by the following means:

The South Carolina Department of Health and Human Services (DHHS) conducts oversight of compliance with section 6032 of the Deficit Reduction Act, regarding employee education about false claims act recoveries through a process that began with sending a bulletin to all providers on January 2, 2007, informing them of their responsibility to comply with this requirement. The department will also add a clause to all provider contracts, including those for managed care organizations (MCOs), informing them of their obligation to comply with these requirements.

SCDHHS, beginning January 15, 2006, and annually thereafter, will develop a report to identify which entities received Medicaid payments totaling more than $5 million in Federal Fiscal Year 2006, to ensure that the State Medicaid Agency identifies aggregate payments that may have been made under more than one provider identification or tax ID number.

The State Medicaid Agency methodology to ensure that these providers comply with the requirements for employee education about False Claims recoveries will include the following components:

1. These providers, the bulk of which include hospitals, the MCOs, nursing homes, and state agencies, will be sent a letter no later than July 1, 2007, requiring them to return a certification statement to SCDHHS attesting that they have in the place the written policies and/or discussions in employee handbooks as required by section 6032 of the DRA. These providers will be required to send in their certification within 30 days upon receipt of the letter. By the end of August 2007 all entities, which meet the $5 million threshold, will be required to certify to DHHS that they are in compliance.

2. The certifications will be confirmed by adding a compliance test to the current audit program for on-site reviews of major Medicaid providers, including MCOs. The SCDHHS Division of Audits will add a compliance test to its audit program for state agencies and MCOs on the 2007 audit schedule. The auditors will verify that these providers have established written policies for all employees, including management, and for any contractor or agent, that include detailed information about the False Claims Act; that they include in the written policies detailed information about their policies and procedures for detecting and preventing fraud, waste, and abuse; and that they include in any employee handbook a specific discussion of the laws described in the written policies, the rights of employees to be protected as whistleblowers, and a specific discussion about the entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

3. The Division of Audits will review state agencies on a revolving schedule, and will plan to have made at least one on-site visit to each state agency and MCO, during which time compliance with section 6032 of the DRA will be verified.

4. Entities which fail to send in their certification within 30 days will be subject to an on-site review to determine why they have not responded and if they do have the policies as required.

5. Nursing homes and hospitals will be audited on a scheduled basis under audit programs which include certain agreed-upon audit procedures. A compliance test for the provisions of section 6032 of DRA will be added to these procedures. Nursing homes will be audited every three years; hospitals every three to five years. The auditors will report to SCDHHS whether these providers are in compliance with the DRA.

6. If, after reviewing the SCDHHS planned audit schedules, the State Medicaid Agency determines that a provider which meets the $5 million test is not scheduled for an on-site audit within the next three to five years, SCDHHS will then require them to furnish the written policies and procedures and any employee handbooks as specified by the provisions of section 6032 of the DRA.

7. Each January SCDHHS will run an updated report to identify which providers received $5 million or more in Medicaid payments during the previous federal fiscal year, and will ensure that these providers are either on a three to five year audit cycle or will require they furnish proof of compliance (by certifying and/or submitting the written policies) with the provisions for Employee Education about False Claims recoveries.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State South Carolina

NONDISCRIMINATION

The South Carolina State Department of Social Services policy and procedures for compliance with the Civil Rights Act of 1964 is on file in the Regional Office. Reference pages 217-222, South Carolina Manual – Volume IV, Revised March 1970.

SOUTH CAROLINA DEPARTMENT OF SOCIAL SERVICES
POST OFFICE BOX
COLUMBIA, SOUTH CAROLINA 29202
(Medical Services Section)

METHODS OF ADMINISTRATION REGARDING COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964 FOR THE STATE OF SOUTH CAROLINA

I. Assignment of Responsibility

The person assigned the responsibility for determining compliance with Title VI of the Civil Rights Act is Roy T. Loyd, Civil Rights Coordinator, State Department of Social Services. We have also trained a number of State Office staff, for example, District Directors and Supervisors to review nursing homes, local Department of Social Services' offices, and physicians' offices. Forms have been devised for review purposes.

II. Discrimination of Information

All applicants for assistance or services from the Department are provided with a brochure describing the rights and responsibilities of the individual under Title VI. Numerous staff meetings and training sessions are held to describe the procedure used to advise the individual staff members of their responsibilities. Each voucher signed by a vendor carries the statement that he is in compliance with Title VI of the Civil Rights Act of 1964. All contracts with vendors include a signed assurance of compliance under Title VI.

In addition to providing each applicant/recipient with a copy of the brochure regarding Title VI, the provisions of the Civil Rights

Act of 1964 are explained, at least two times annually, to recipients or potential recipients at each contact by agency personnel. There is also a statement on the Basic Information Form which the client signs at the time of application which calls to his attention the rights under Title VI of the Civil Rights Act of 1964. This statement is also included and called to the attention of the recipient at the times of each review (Copies attached).

The general public is advised of Title VI provisions by various means. All printed brochures, etc., which outline the services of the agency include statements regarding Civil Rights. Each staff member who has any contact with the general public, and especially minority groups, has been instructed to place special emphasis on the provisions of Title VI.

III. Maintaining and Assuring Compliance

The Department has developed a form for use in reviewing nursing homes, hospitals, and doctors' offices. The Agency has developed a schedule whereby all vendors will be reviewed annually whenever possible. We also have provisions for reviewing the local County Departments to assure that they are in compliance. The local Social Services Agencies are reviewed at a scheduled rate of ten to twelve per quarter so that they may all be reviewed during the calendar year. (We have 46 counties in South Carolina). A list of physician vendors has been compelled by the State and in counties with twenty-five physicians or less, the

physicians are reviewed on an annual basis. In counties with twenty-five to one hundred physicians, they are reviewed bi-annually. Counties with more than one hundred physicians vendors should have at least 20% of these physicians reviewed on an annual basis. As stated above, all reviews are conducted by trained State staff using the format developed by the Title VI Coordinator and the Staff Development and Training Section.

Skilled and intermediate care nursing homes are required to submit Title VI compliance data to the State Civil Rights Coordinator, using the Department of Health, Education, and Welfare/Office for Civil Rights approved format. The completed nursing home compliance information is submitted to the Regional Office for Civil Rights on (at least) a quarterly basis for their comment and evaluation.

In addition, periodic on-site visits will be continued at all skilled and intermediate nursing facilities. Copies of the completed review guides, like all other Title VI compliance information will be maintained in the State Civil Rights Coordinator’s office. Such compliance information and reports will be reviewed by the State Civil Rights Coordinator as it is received. If this data reveals that additional information is needed or if any vendor or local agency, has not fully complied under the Regulations, the State Civil Rights Coordinator will initiate appropriate requests for additional information or corrective action.

Since all Medicaid approved hospitals within the State also participate in the Medicare program, the State has agreed to rely upon the Regional Office for Civil Rights for compliance determination information. However, the state is expected to assume review responsibility for hospitals at a later date.

IV. Handling Complaints

Complaints may be filed with the Commissioner, State Department of Social Services, the Civil Rights Coordinator, the County Departments of Social Services, or the Office for Civil Rights, Atlanta, Georgia. Any complaint which is registered requires a visit from either the Civil Rights Coordinator or one of the trained State Consultants. If complaints against vendors to Department of Social Services cannot be resolved through negotiation, vendor payments will be discontinued. Following this action, local Department of Social Services Agencies and other State Agencies will be notified that the vendor has failed to comply with the requirements of Title VI of the Civil Rights Act of 1964.

Complainants are encouraged to file written complaints within 150 days after any alleged act of discrimination based on race, color, or national origin. In accordance with state policy, the initial complaint investigation will be conducted within seven days after its receipt. Complainants will receive a written confirmation of the receipt of

their complaint and a report of the completed complaint investigation. Whenever possible, complaints will be resolved within 30 days after the initial complaint investigation.

V. Recruitment and Training Programs

All recruitment, employment, training and promotion of employees under our jurisdiction and/or control is without discrimination to race, religion, color, political affiliation, physical disability, age, national origin, or sex except where sex or age is a bonafide occupational qualification.