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Document No. 4746
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CHAPTER 126
Statutory Authority: 1976 Code Section 44-6-90

- 126-400. Definitions.
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- 126-425. Recipient Utilization.
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- 126-560. The Commission 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 recipients.
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- 126-800. Definitions.
- 126-810. Imposition of Sanctions.
- 126-830. Assessment of Sanctions.
- 126-840. Schedule of Sanctions.

Preamble:

The South Carolina Department of Health and Human Services is proposing to amend Article 4, Article 5, Article 7 and Article 8 of Chapter 126 of the South Code of Regulations to update outdated references, to more accurately reflect administration of the Agency's programs and to remove sections that are no longer administered by the Agency.

Section-by-Section Discussion:

126-400. Definitions.

- A. Replaces "recipient" with "beneficiary".
- B.-E.No change.
- F. Changes definition of "Fraud" to reflect federal regulatory definition.
- G. No change.
- H. Changes definition of "Exclusion" to more closely reflect federal regulatory definition.
- I. Adds definition for "Suspension of Payment" to more closely reflect administration of the Agency's program.
- J. Changes definition of "Termination" changed to more closely align with federal regulations.
- K. Adds new definition of "Suspension" to more closely reflect federal regulatory definition.

126-401. Sanctions.

A. Removes “Recoupment of Overpayment(s)” as a possible sanction since Agency has no discretion to not recoup overpayments under federal rules.

B. Amended to be more consistent with federal regulations regarding administrative sanctions against providers. Removes “Recoupment of Overpayment(s)” as a possible sanction since Agency has no discretion to not recoup overpayments under federal rules. Adds “Exclusion” as a possible administrative sanction 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.

126-403. Grounds for Sanction.

A.-C. No change.

D. Replaces “recipients” with “beneficiaries”.

E. No change.

F. No change.

G. Replaces “recipient” with “beneficiary”.

H.-K. No change.

L. Updates federal regulatory reference.

M.No change.

N.No change.

O. New ground added to be consistent with federal regulations.

126-404. Fair Hearings.

A. Changes outdated reference from “Bureau of Medicaid Program Assessment” to “Department”.

B. Changes outdated reference from “Health Care Financing Administration” to “Centers for Medicare and Medicaid Services”. Updates federal regulatory reference.

126-405. Reinstatement.

Amended to more closely align with federal regulations regarding reinstatement after Department-initiated exclusion.

126-425. Recipient Utilization.

A. Replaces “recipient” and “recipients” with “beneficiary” and “beneficiaries”.

B. Replaces “recipient” and “recipients” with “beneficiary” and “beneficiaries”.

126-500. Definitions.

A. Replaces “Commission” with “Department” and “State Health and Human Services Finance Commission” with “South Carolina Department of Health and Human Services”.

B.-M. No change.

126-505. Responsibilities for Eligibility Determination.

A. Replaces “Commission” with “Department”.

B. Replaces “Commission” with “Department”.

C. Replaces “Commission” with “Department”.

126-510. Application Process.

- A.-H. No change.
- I. Replaces “Commission” with “Department”.

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

- A. No change.
- B. Replaces “SHHFSC” to “the Department”.

126-560. The Commission 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 recipients.

- Title changed. “Commission” replaced with “Department” and “recipients” replaced with “beneficiaries”.
- A. No change.
 - B. Replaces “State Health and Human Services Finance Commission” with “South Carolina Department of Health and Human Services” and deletes outdated reference to “Department of Hospital Rate Setting” and replaces with “Department”.

126-570. Grace Period.

Replaces “State Health and Human Services Finance Commission” with “South Carolina Department of Health and Human Services”.

126-710. General.

Deleted in its entirety.

126-720. Scope of Program and Services.

- A. Deleted in its entirety.
- B. Deleted in its entirety.

126-730. Persons Eligible to Receive Social Services.

Deleted in its entirety.

126-740. Application Procedures.

- A. Deleted in its entirety.
- B. Deleted in its entirety.

126-750. Client Right to Appeal.

Deleted in its entirety.

126-799. Prior Regulations.

Deleted in its entirety.

126-800. Definitions.

- A. Replaces “State Health and Human Services Finance Commission” with “South Carolina Department of Health and Human Services”.
- B. No change.
- C. No change.
- D. Replaces “Health Care Financing Administration (HCFA)” with “Centers for Medicare and Medicaid Services (CMS)” and add “US” to the acronym “DHHS”.
- E.-M. No change.
- N. Replaces “State Health and Human Services Finance Commission (SHHSFC)” with “South Carolina Department of Health and Human Services (SCDHHS)”.
- O. No change.
- P. No change.
- Q. No change.

126-810. Imposition of Sanctions.

Replaces “invoke” with “apply”. Clarifies that payment can be denied for “all individuals” under the Medicaid program. Adds the following possible sanctions: denial of payment for new admissions under the Medicaid program, transfer of residents, and closure of a facility and transfer of residents.

126-830. Assessment of Sanctions.

Deletes references to “conducted after October 1, 1990”.

126-840. Schedule of Sanctions.

CLASS III DEFICIENCY

- A. No change.
- B. Replaces “Health Care Financing Administration” with “Centers for Medicare and Medicaid Services”

The Notice of Drafting was published in the *State Register* on December 23, 2016.

Notice of Public Hearing and Opportunity for Public Comment:

Should a hearing be requested pursuant to Section 1-23-110(A)(3) of the 1976 Code, as amended, such a hearing will be conducted at the Administrative Law Court, 2nd Floor Hearing Room, Edgar A. Brown Building, 1205 Pendleton Street, Columbia, South Carolina on Tuesday, April 18, 2017, beginning at 3:00 p.m. Written comments may be directed to Colleen Mullis, Deputy Communications Director, South Carolina Department of Health and Human Services, 1801 Main Street, Suite 1100, Columbia, SC 29201, no later than 5:00 p.m., March 27, 2017. If a qualifying request pursuant to Section 1-23-110(A)(3) is not timely received, the hearing will be canceled.

Preliminary Fiscal Impact Statement:

There will be no cost incurred by the State or any of its political subdivisions.

Statement of Need and Reasonableness:

DESCRIPTION OF REGULATION:

Purpose: The Agency is proposing to amend Article 4, Article 5, Article 7 and Article 8 of Chapter 126 of the South Code of Regulations to update outdated references, to more accurately reflect administration of the Agency's programs and to remove sections that are no longer administered by the Agency.

Legal Authority: 1976 Code Section 44-6-90.

Plan for Implementation: The revised regulation will take effect upon approval by the General Assembly and upon publication in the State Register. SCDHHS will notify the public of the revised regulation and post the revised regulation on the Agency's web site.

**DETERMINATION OF NEED AND REASONABLENESS OF THE PROPOSED REGULATION
BASED ON ALL FACTORS HEREIN AND EXPECTED BENEFITS:**

The Agency needs to amend Article 4, Article 5, Article 7 and Article 8 of Chapter 126 of the South Code of Regulations to update outdated references, to more accurately reflect administration of the Agency's programs and to remove sections that are no longer administered by the Agency.

DETERMINATION OF COSTS AND BENEFITS:

There is no cost incurred by the state.

UNCERTAINTIES OF ESTIMATES:

There are no uncertainties of estimates concerning the regulations.

EFFECT ON ENVIRONMENT AND PUBLIC HEALTH:

This regulation will have no effect on the environment. This regulation contributes to the Agency's function of administering its health programs in the most effective and efficient ways possible.

**DETRIMENTAL EFFECT ON THE ENVIRONMENT AND PUBLIC HEALTH IF THE REGULATION
IS NOT IMPLEMENTED:**

There will be no detrimental effect on the environment and public health of this State if the revisions to this regulation are not implemented.

Statement of Rationale:

The Agency is proposing to amend Article 4, Article 5, Article 7 and Article 8 of Chapter 126 of the South Code of Regulations to update outdated references, to more accurately reflect administration of the Agency's programs and to remove sections that are no longer administered by the Agency.

Text:

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 ~~recipient~~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 - ~~as determined by a court of appropriate jurisdiction~~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 items or services furnished by a specified practitioner, provider, or other supplier of services will not be reimbursed under Medicaid~~ 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 - an exclusion of a Medicaid provider from participation in the Medicaid Program~~ 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 - a permanent exclusion of a Medicaid provider from participation in the Medicaid Program~~ 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].

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) Recoupment of Overpayment(s);~~
- ~~(3) Postpayment Review of Claims;~~
- ~~(4) Prepayment Review of Claims;~~
- ~~(5) Referral to Licensing/Certifying Boards or Agencies;~~
- ~~(6) Peer Review;~~
- ~~(7) Suspension;~~
- ~~(8) 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) Recoupment of Overpayment(s);~~
- ~~(2) Suspension;~~
- ~~(3) Termination;~~
- (3) Exclusion.

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.

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 ~~recipients~~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 ~~recipient~~beneficiary to receive service(s) or merchandise not otherwise required by the ~~recipient~~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 ~~Section 420, Part B~~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]

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 ~~Bureau of Medicaid Program Assessment~~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 420, Part B~~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 ~~Health Care Financing Administration~~Centers for Medicare and Medicaid Services. Appeals to the ~~Health Care Financing Administration~~AdministrationCenters for Medicare and Medicaid Services shall be processed exclusively in accordance with ~~42 CFR Section 420.128~~42 CFR Part 1005, and the individual practitioner shall not have a right to another appeal before the Single State Agency.

126-405. Reinstatement.

~~At the conclusion of the period of time a Medicaid provider has been suspended or at any time thereafter, a provider may be eligible for readmission to the Medicaid Program. Those who wish to seek readmission shall comply with provisions of the Letter of Notice of Exclusion from the South Carolina Medicaid Program. 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)].~~

SUBARTICLE 2 PROGRAM INTEGRITY

126-425. ~~Recipient~~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 ~~recipients~~beneficiaries and health care providers.

(2) Medicaid ~~Recipient~~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) ~~Recipient~~Beneficiary Profile - a comprehensive statistical and utilization profile of a Medicaid ~~recipient~~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 ~~recipient~~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 ~~recipient~~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. ~~Recipient~~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) ~~Recipients~~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 ~~recipient~~beneficiary;

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

(3) ~~Recipient~~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) ~~Recipients~~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 ~~recipients~~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 recipient/beneficiary;
 - (j) The degree of compliance with medical advice and treatment pathways;
 - (k) Evidence that a recipient/beneficiary's medical outcomes and health status may be improved by following treatment pathways and coordinated care.
- (7) Rights and conditions of recipient/beneficiary during restriction period.
- (a) Recipients/Beneficiaries will be notified by mail of a pending restriction or action subject to 42 CFR 431.206 through 42 CFR 431.214.
 - (b) Recipients/Beneficiaries are given freedom of choice of their primary providers. If a recipient/beneficiary does not select a primary provider, DHHS may select one for the recipient/beneficiary.
 - (c) A Recipient/beneficiary will be released from restriction upon DHHS determination that the recipient/beneficiary's service utilization patterns are in compliance with treatment pathways and consistent with their medical needs.
- (8) Fair Hearing - any Medicaid recipient/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.

ARTICLE 5
MEDICALLY INDIGENT ASSISTANCE PROGRAM (MIAP)

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

126-500. Definitions.

A. "~~Commission~~Department" means the ~~State~~South Carolina Department of Health and Human Services Finance Commission.

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.

126-505. Responsibilities for Eligibility Determination.

A. The ~~Commission~~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 ~~Commission~~Department of who is designated to determine eligibility in the county. The ~~Commission~~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 ~~Commission~~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 ~~Commission~~Department. If a county has elected to review claims prior to submission to the ~~Commission~~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 ~~Commission~~Department.

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 ~~Commission~~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 ~~Commission~~Department Appeals and Hearing Regulations, R.126-150 et seq.

SUBARTICLE 2 COVERED SERVICES

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 ~~SHHSFC~~the Department the amount reimbursed to the hospital by that person.

SUBARTICLE 3 PAYMENT PROCESS

126-560. The ~~Commission~~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 ~~recipients~~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

~~State Health and Human Services Finance Commission~~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 of Hospital Rate Setting~~, he may appeal that decision in accordance with R_126-150 et seq.

SUBARTICLE 4 COUNTY ASSESSMENTS

126-570. Grace Period.

County Assessments shall be paid in accordance with the provisions of 44-6-146© 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©. 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

~~State Health and Human Services Finance Commission~~South Carolina Department of Health and Human Services

Post Office Box 8206

Columbia, South Carolina 29202-8206

ARTICLE 7 SOCIAL SERVICES BLOCK GRANTS

~~126-710. General.~~

~~In August 1981, Congress passed Public Law 97-35 which amended Title XX to create the Social Services Block Grant (SSBG). The primary responsibility for the program was given to the states with flexibility, within broad federal guidelines, to develop and administer social service programs reflective of state priorities and concerns. The State Health and Human Services Finance Commission has been designated as the agency to administer the program in South Carolina.~~

~~126-720. Scope of Program and Services.~~

~~A. A broad array of social services identified in the SSBG Plan are available to any individual determined eligible in order that they may improve their quality of life and economic well being.~~

~~B. Services funded by the Social Services Block Grant shall be delivered by:~~

~~(1) Private organizations who have contracted with the administering agency; and/or~~

~~(2) Public organizations who have contracted with the administering agency.~~

~~126-730. Persons Eligible to Receive Social Services.~~

~~Any individual meeting the eligibility criteria as described in the SSBG Plan is eligible to receive any services described in the SSBG Plan and offered in their geographic area.~~

~~126-740. Application Procedures.~~

~~A. Any individual or his representative may apply for services at any county Department of Social Services.~~

~~B. Eligibility determination shall be made within thirty (30) days of application.~~

~~126-750. Client Right to Appeal.~~

~~The client has the right to appeal any action taken with regard to his application for eligibility or services offered.~~

~~126-799. Prior Regulations.~~

~~These regulations supersede any regulations previously promulgated concerning Title XX or Social Services Block Grant.~~

ARTICLE 8

INTERMEDIATE SANCTIONS FOR MEDICAID CERTIFIED NURSING FACILITIES

126-800. Definitions.

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

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 Health Care Financing Administration (HCFA) 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 ~~State Department of Health and Human Services Finance Commission (SHHSFCSDHHS)~~.

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.

126-810. Imposition of Sanctions.

The Administrator, or his designee, of the State Medicaid Agency may ~~invoke~~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.

~~23.~~ Assess and collect monetary penalties in accordance with Sections 126-830 and 126-850 of these regulations.

~~34.~~ Seek court appointment of temporary management.

5. Transfer of residents.

6. Closure of a facility and transfer of residents.

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 ~~conducted after October 1, 1990~~, may be assessed at double the scheduled amount.

Recurring deficiencies identified from previous annual standard survey ~~conducted after October 1, 1990~~, 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.

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 ~~Health Care Financing Administration~~ 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.