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PROGRAM DESCRIPTION

MISSION STATEMENT

The mission of the Optional State Supplementation (OSS) program is to enhance the quality of life for Medicaid consumers living in licensed Community Residential Care Facilities (CRCFs). The OSS program is committed to promoting and sustaining the health of residents in CRCFs. The program is necessary to improve quality of life and prevent or delay premature institutionalization of residents by providing evidenced-based, innovative, and person-centered care and services.

OVERVIEW

The Optional State Supplementation program was authorized by federal law through amendments to the Social Security Act. Each state is given the option of providing OSS assistance to help persons with needs not fully covered by Supplemental Security Income (SSI). The OSS is a monetary payment based on need and paid on a monthly basis.

As this is an optional program, each state determines whether it will participate in the OSS program. South Carolina currently provides an OSS payment to all SSI beneficiaries and other low-income individuals who: (1) meet the state's net income limits, (2) reside in a licensed CRCF that is enrolled in the OSS program, and (3) meet all other SSI criteria. All OSS beneficiaries are eligible for Medicaid as well, and are therefore entitled to Medicaid-covered services. The South Carolina Department of Health and Human Services (SCDHHS) eligibility office uses federal guidelines to determine financial eligibility for the South Carolina OSS program.

OSS beneficiaries keep a portion of their monthly income for personal needs. The Personal Needs Allowance (PNA), Net Income Limit (NIL), and OSS payment level are adjusted through the South Carolina legislative budgetary process and mandated by proviso annually. OSS is funded entirely by the state and is not matched with federal funds (Regulation 126-940).

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PROGRAM DESCRIPTION

PROGRAM PROCEDURES

The Medicaid eligibility office is charged with the responsibility of determining the applicant's financial eligibility for the OSS program. If the applicant meets the requirements, the Medicaid eligibility office notifies the OSS Program Area that the applicant is entitled to OSS services. Providers must refer to "Eligibility Criteria" later in this section for detailed eligibility information.

A monthly payment is made on behalf of the OSS participant to the facility where the participant resides to cover the difference between the participant's monthly countable income and the OSS net income limit. The OSS payment is considered payment in full, and any differences in the payment amount due to rounding in the system cannot be charged to the resident or the responsible party.

OSS payments are made to the facility two months after the service date. Payments are made on the first Friday of each month. For example, January services are paid on the first Friday in March.

Waiting List Policy

A projected number of OSS slots and enhanced services are made available for residents throughout the fiscal year based on annual funding allocation by the South Carolina General Assembly. This number may be adjusted according to usage rates and other factors. If the number of individuals receiving and applying for the projected number of OSS slots and enhanced services exceeds program capacity, waiting list procedures are implemented.

Available slots assigned on a first-come, first-served basis provide for a one-for-one replacement of each resident terminated from the OSS program and enhanced services. Priority is given to Adult Protective Service (APS) clients as appropriate. However, APS clients must still be determined eligible and a slot approved prior to admission. OSS payment does not begin until the date the slot and/or service is approved.

Resident Admission to a Facility

When OSS eligibility is determined, an applicant receives a Communication Form (DHHS CRCF-02 — see the Forms section) and takes it to a participating CRCF of choice. Once the applicant is admitted, the CRCF completes Section II (the shaded area) of the Communication Form and returns it to the OSS program area. A delay in returning the DHHS CRCF-02 or the provision of incorrect

SECTION 2 POLICIES AND PROCEDURES

PROGRAM DESCRIPTION

Resident Admission to a Facility (Cont'd.)

or incomplete information may result in a delay of the OSS payment to the facility. This CRCF-02 form is only valid for a period of 30 days from the date issued and must be returned to the **OSS PROGRAM AREA** within the 30-day period.

Notice of Admission

The county eligibility office initiates a Notice of Admission, Authorization & Change of Status For Community Residential Care Facility (DHHS CRCF-01) by completing Section I (Client Information) and Section IV B&C (Countable Income and Personal Needs Allowance). This form is signed and dated by the county eligibility worker and sent to the facility. (An example of the form can be found in the Forms section.)

The facility receives the DHHS CRCF-01 and completes the information necessary for payment; a copy is kept for the facility's files. The facility attaches the DHHS CRCF-01 to the monthly Turn Around Document (TAD) and adds the new resident to the last page of the TAD. All DHHS CRCF-01s completed during the month must be attached to the TAD when it is submitted for payment processing. See Section 3 for detailed descriptions of the TAD and the DHHS CRCF-01.

Note: A DHHS CRCF-01 must be included in the month's payment request for every change on that month's TAD. Changes include all admissions, discharges, transfers, and deaths.

Personal Needs Allowance

The Social Security Administration mandates the personal needs allowance (PNA). A resident is allowed to keep an allowance for personal needs such as clothing, personal laundry, toiletries, and incidentals, in addition to any income that was disregarded by the county eligibility office during the eligibility process. The amount of the personal needs allowance is determined by the state General Assembly each year. Use of the allowance is at the resident's discretion.

The personal needs allowance must be deducted from other social security income the resident receives, and must be credited to the resident at the beginning of each month. The personal needs allowance is not deducted from the OSS payment. Residents must sign documentation monthly stating they have received their personal needs allowance

SECTION 2 POLICIES AND PROCEDURES

PROGRAM DESCRIPTION

Personal Needs Allowance (Cont'd.)

and the amount received. If the resident is unable to sign for his/her personal needs allowance, the facility must have a policy in place regarding confirming the personal needs allowance was given to the resident.

Remittance Advice

The provider must retain at least 13 previous months of SCDHHS remittance advices, and be able to accurately account for each resident's monies. Remittance advices must be made available to SCDHHS representatives upon request. Providers can view, save, and print their own remittance advices on the SC Medicaid Web-Based Claims Submission Tool. For more information see Section 3 Billing Overview and Claim Processing.

Resident Assessments

The South Carolina Department of Health and Human Services conducts medical assessments of Optional State Supplementation (OSS) residents. These medical assessments are required of all residents within the program. The assessments will be in the form of a survey. The new medical assessment policy will not affect the resident's standing within the program. The assessment will help to improve the overall quality of the OSS program for all involved.

The survey/assessment will be done by a SCDHHS nurse at the CRCF where the resident resides. An assessment will NOT be required prior to admission into a CRCF. The resident's assessment will occur after admission to the facility and every 36 months thereafter.

Bed Holds – Medical Absence

A bed hold is for when a resident is admitted to a hospital or some other type of health care facility for short-term care. If the resident is expected to return, the CRCF agrees to reserve their bed for a designated period. The OSS benefit payment may continue if the absence from the facility is expected to last less than 30 consecutive calendar days.

If the OSS payment is being continued during a temporary absence due to a medical confinement, no other person is allowed to occupy the resident's space during that time period.

If a resident enters a medical facility and is expected to be absent from the CRCF longer than 30 consecutive calendar days, the resident must be terminated from the TAD as a

SECTION 2 POLICIES AND PROCEDURES

PROGRAM DESCRIPTION

Bed Holds – Medical Absence (Cont'd.)

discharge, effective the day of the medical facility admission. Reimbursement cannot be claimed for the date of discharge.

Examples

The following scenarios illustrate some possible applications of this policy:

Case 1 A resident has a severe medical/psychiatric crisis and is admitted to an acute care setting; he or she is not expected to return to the CRCF. The facility completes a DHHS CRCF-01 and discharges the resident effective the date of transfer.

Case 2 A resident enters the hospital on November 27 and is expected to stay in the hospital for approximately 30 days. The CRCF implements the medical absence policy and submits the required information with the TAD to the provider service center.

Case 3 A resident enters the hospital and is expected to stay longer than 30 days. The facility completes a DHHS CRCF 01 and discharges the resident effective the date of transfer. The facility immediately sends a copy of the DHHS CRCF 01 to the OSS PROGRAM AREA and another copy to the county eligibility office so that another applicant can be issued that client's slot. The eligibility office must notify SSA of the client's new location. The facility retains a copy for DHHS CRCF 01 to submit with the TAD for payment.

Bed Holds – Non-Medical Absence

Typically, non-medical absences are visits that a resident makes to a family member's home for greater than one calendar day. A calendar day is defined as a full 24-hour period beginning and ending at midnight.

A resident can have up to 45 days per calendar year with no more than 10 consecutive days of non-medical bed holds.

If a resident is incarcerated, the CRCF facility must discharge the resident. This is not considered a non-medical bed hold.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM DESCRIPTION

Examples

The following scenarios illustrate some possible applications of this policy:

Case 1 A resident goes to a family member's home for a temporary stay during the holidays. The resident leaves on December 22 and returns on December 27. The resident was away from the CRCF for four days and cannot receive OSCAP reimbursement for those four days. The facility completes a DHHS CRCF-01 and sends a copy with the TAD the following month.

Case 2 A resident goes to a family member's home on January 1 and returns to the facility on January 2. The temporary non-medical absence policy does not apply because the resident's absence did not exceed one calendar day. No action is required by the CRCF.

Reimbursement for OSCAP services is not allowed for any absence from the CRCF; payment reverts to the OSS rate for any days the resident is away from the facility.

Resident Transfer

The OSS program allows a participant to transfer from one CRCF to another at any time during his or her OSS eligibility as long as the new facility agrees to accept the participant and the facility is an enrolled OSS provider. The assigned OSS slot will transfer with the resident to the new facility. The receiving facility must request verification of the OSS participant's eligibility status before accepting him or her as a new resident. The current/new facility initiates a DHHS CRCF 01 by completing Section I and Section III A and submitting the CRCF-01 form to the OSS program area. The transferring Facility completes the CRCF-01 form and faxes to the OSS program area at 803-255-8209.

Resident Termination

Within 72 hours of the termination, the current facility initiates a DHHS CRCF-01 by completing Section I and Section III B. Copies of this DHHS CRCF-01 are submitted to the county eligibility office. You do not need an eligibility worker's signature to submit a terminating CRCF-01 form with your TAD. The original form is attached to the monthly TAD after making the necessary

SECTION 2 POLICIES AND PROCEDURES

PROGRAM DESCRIPTION

Resident Termination (Cont'd.)

changes on the TAD. The facility must retain a copy of CRCF-01 form. **Reimbursement cannot be claimed for the date of discharge.**

The only exception to this is if the OSS participant enters the facility and dies on the same day. The facility can claim reimbursement for this date.

CRCF Admits Resident

Within 72 hours of the admission, the new/receiving facility initiates a DHHS CRCF-01 by completing Section I and submits the DHHS CRCF-01 to the central mail location.

The eligibility caseworker reviews Section I and completes section IV signs, dates, and returns the DHHS CRCF-01 to the facility. The receiving facility attaches the DHHS CRCF-01 to the monthly TAD, and makes the necessary changes, which in the case of a transfer, would be the addition of a new resident to the TAD. Reimbursement may be claimed for the date of admission.

Resident No Longer OSS Eligible

In the event a resident is no longer eligible for Medicaid, the OSS eligibility is forfeited. The eligibility caseworker initiates the DHHS CRCF-01 by completing Section I and checking the financially ineligible box in the Section IV. The eligibility office forwards the DHHS CRCF-01 to the facility and submits a copy to the OSS PROGRAM AREA. The facility attaches the original DHHS CRCF-01 to the monthly TAD and makes necessary changes. The termination date is the last day of OSS eligibility or the date of discharge, whichever is earlier. The OSS PROGRAM AREA updates the data system when any of these changes are made.

Income Changes

A change in an OSS participant's monthly income may result in a change or termination of the OSS payment. All changes must be reported to the county eligibility office. Changes may be reported by the facility on the DHHS CRCF-01. Any cost of living adjustments to Social Security, SSI, or OSS will be automatically calculated and reported by the county eligibility office.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM DESCRIPTION

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SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

PROVIDER QUALIFICATIONS

For a facility to participate in the Optional State Supplementation program (OSS), it must meet all of the following requirements:

- Provide evidence of licensure in good standing as a Community Residential Care Facility (CRCF) by the South Carolina Department of Health and Environmental Control (DHEC). Licensing regulations are set by Regulation 61-84 (revised 06/26/2015). A facility that wishes to become licensed must contact the Division of Health Licensing at (803) 545-4370.
- Properly and accurately complete the online enrollment application located on SCDHHS website: http://scdhhs.gov/provider
- Comply with all requirements in the Facility Participation Agreement for the OSS program.
- Comply with all federal and state laws and regulations currently in effect, as well as all policies, procedures, and standards required by the Medicaid program.
- Utilize the automated systems mandated by SCDHHS to document and bill for the provision of services.
- All new OSS providers are required to attend a mandatory SCDHHS process and procedure training.
- The CRCF is responsible for updating the bed locator at least monthly on the following website: www.nfbl.sc.gov

Provider Enrollment

A facility must enroll in the OSS program with SCDHHS before receiving reimbursement for OSS residents. The facility's authorized representative is required to complete the online provider enrollment application. Providers must contact the South Carolina Provider Service Center (PSC) at 888-289-0709, Option 4 or submit an online inquiry at http://www.scdhhs.gov/contact-us for additional information.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Facility Participation Agreement and Sanctioning Process

The Facility Participation Agreement and Sanctioning Process includes the following key elements:

- Licensure in good standing by DHEC
- Assurance of one composite electronic fund transfer
- Facility documentation of resident funds and personal needs allowance
- Facility underpayment or overpayment adjustments
- Facility notification to DHHS regional offices and the eligibility offices of admissions, discharges, transfers, and deaths within 72 hours
- Monthly processing of the OSS payments
- Approval of payment of new OSS beneficiaries
- Medical absences
- Quality and scope of services
- Annual rate determination
- Freedom of choice
- Record keeping
- Assurance of compliance with OSS program policies and procedures
- Sanctioning process
- Termination
- Appeals

By signing the Facility Participation Agreement and Sanctioning Process, the facility representative acknowledges that the execution of the Facility Participation Agreement makes the facility eligible to participate in the OSS program. The facility is not guaranteed any specific level of OSS participation. SCDHHS may terminate when serious infractions occur.

Freedom of Choice

An OSS participant has the right to choose any CRCF willing to accept the participant as a resident provided the facility maintains licensure in good standing with DHEC and is enrolled with SCDHHS as a participating facility.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

OSS ELIGIBILITY CRITERIA

The county eligibility office is charged with the responsibility of determining the financial eligibility of an individual who wishes to participate in the OSS program.

An individual may be eligible to participate in the OSS program if he or she currently receives SSI. In this case, completion of an application to determine eligibility is not necessary. However, the SSI participant must read and sign the SSI Recipient Request for Optional State Supplementation (Form 1728) to acknowledge that he or she wishes to enter an enrolled facility. This procedure may be completed at the eligibility office of the county in which the participant resides or may be completed electronically. A copy of this (Form 1728) is located in the Forms section of this manual.

If an individual is not receiving SSI, an OSS application must be completed and eligibility determined by the county eligibility office. An application may be completed at any county eligibility office and most hospitals. At the time an application is made, the following information must be presented for verification:

- Proof of income
- Social Security number
- Bank statements
- Life and health insurance information
- Name and address of CRCF (if the individual is already residing in a facility)

For reference, a list of all Medicaid applications and county eligibility offices is located in the Forms section of this manual.

To receive OSS, a person must meet all of the following criteria:

- Be age 65 or older, blind, or disabled
- Have income and financial resources within certain limits
- Be a citizen of the United States of America or meet certain citizenship requirements
- Be a resident in a licensed and enrolled CRCF and a Medicaid eligibility decision

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Appeals

If the eligibility office finds that an applicant does not meet financial requirements and denies him or her financial eligibility, an appeal may be filed. The appeal must be filed in writing, within 30 days of the date of notice. The SCDHHS Division of Appeals will handle these appeals. You should carefully read the notice or denial you receive. It will contain instructions on how to appeal.

An individual may appeal an eligibility determination by submitting a statement of reconsideration and a copy of the denial notice to SCDHHS by one of the following methods:

- **Online at www.scdhhs.gov/appeals.** You will receive an electronic confirmation via email after submitting an appeal.
- **Fax to:** (803) 255-8274 or (888) 835-2086
- **Mail to:**

  SCDHHS
  PO Box 100101
  Attn: Eligibility Appeals
  Columbia, SC 29202

- **Email to**: eligappeals@scdhhs.gov

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

OPTIONAL SUPPLEMENTAL CARE FOR ASSISTED LIVING PARTICIPANTS (OSCAP)

The Optional Supplemental Care for Assisted Living Participants (OSCAP) service gives additional reimbursement to facilities to provide assistance with personal care for residents who meet the medical criteria required for participation.

Referral Process for OSCAP

Referrals for the OSCAP service may be submitted electronically via the following link:

https://phoenix.scdhhs.gov/initial_electronic_referrals/new

OSCAP Eligibility Criteria

In addition to the OSS Eligibility criteria, a participant must meet the medical necessity criteria described below to receive OSCAP services.

Medical Necessity

Medical necessity determination for OSCAP services includes the following:

- The applicant must have a cognitive impairment and one functional dependency, or
- The applicant must have two functional dependencies.

Functional Dependency

A functional dependency is an inability to perform an activity of daily living (ADL) independently, thereby requiring limited assistance from another person to perform the activity.

The seven functional areas of ADL are:

- Transferring
- Loss of motion
- Bathing and personal grooming
- Dressing
- Eating and meal set up
- Toileting
- Bladder/Bowel Incontinence

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Cognitive Impairment

Participants are eligible for OSCAP services when they require one or more of the following services for cognitive impairment:

- Supervision of moderate/severe memory, either long or short-term, manifested by disorientation, bewilderment, and forgetfulness, which requires significant intervention in overall care planning
- Supervision of moderately impaired cognitive skills manifested by decisions, which may reasonable be expected to affect an individual's own safety
- Supervision of moderate problem behavior manifested by verbal abusiveness, physical abusiveness, or socially inappropriate/disruptive behavior
- Supervision of frequent mood episodes

OSCAP and Hospice Services

Beneficiaries of Hospice and OSCAP may only receive personal care through one service or the other; therefore, they must choose either Hospice or OSCAP. An OSCAP participant residing in a CRCF has the right to choose which service they receive, as well as the option to choose the provider who delivers that service, if all medical necessity criteria are met.

OSCAP services will transfer with the resident to OSCAP enrolled providers. Providers are responsible for contacting the SCDHHS nurse to inform him or her of the transfer. The receiving provider is responsible for sending the most recent care plan to the SCDHHS nurse to receive a new service plan and authorization. The new facility has seven days to inform SCDHHS of the new OSCAP admission.

Termination of Authorized Services

The OSCAP nurse will terminate services when a participant is determined medically or financially ineligible, or no longer resides in the OSCAP authorized CRCF.

The provider will be notified of the termination of services by written contact. Verbal notification must be followed with a written confirmation of termination of the service.

A participant has the right to request an appeal of the action. The CRCF must assist the participant in providing a timely request for appeal.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

OSCAP PROVIDER QUALIFICATIONS AND RESPONSIBILITIES

For a facility to participate in the OSCAP program, it must be in good standing with SC DHEC and meet all of the OSS requirements in addition to the following:

- Provide evidence of no uncorrected Class I and Class II violations of licensing regulations within one year prior to the date of its application to provide OSCAP services. Facilities cited for repeated violations are considered to have operated with an uncorrected violation. Before a contract is issued, there must be evidence the plan of correction has been implemented and the problem has been addressed.
- Meet basic requirements of the Americans with Disabilities Act (ADA) including wheelchair accessibility. See ADA checklist in the Forms section of this manual.
- In the event the CRCF is licensed for more than 16 beds or is part of a larger entity that exceeds 16 beds, the CRCF must have a case mix that does not maintain a census in which more than 45% of residents whose current need for placement as determined by SCDHHS is due to a mental illness.

The CRCF must implement admission policies that facilitate maintaining, at a minimum, one fully functioning ADA Compliant bathroom accessible to individuals with physical impairments.

OSS and OSCAP Working Capital

Providers must maintain a minimum working capital level to provide OSS and OSCAP services. Working capital is defined as the difference between current assets and current liabilities in any given month. It is the capital available for the operations of a business. It allows the CRCF to perform its day-to-day activities and meet its functional requirements. The minimum working capital levels are:

- 4-10 Beds - $2,500
- 11-25 Beds - $5,000
- 26 and above – $10,000

Documentation of working capital must be provided to SCDHHS representatives upon request.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

OSCAP Freedom of Choice

An OSCAP participant has the right to choose any CRCF contracted to provide OSCAP services and willing to accept the participant as a resident.

OSCAP Provider Responsibilities

Provider's responsibilities include, but are not limited to:

- The CRCF is responsible for meeting certain facility, staff, and documentation requirements to provide OSCAP services.
- The CRCF must provide the supplies needed to provide personal care to the resident and to maintain his or her personal cleanliness. These include, but are not limited to:
  - Soap
  - Shampoo
  - Toothbrush or denture brush/cleaner
  - Diapers, briefs, or pads (if needs exceed Medicaid State Plan service)
  - Razors
  - Shaving lotion or shaving cream
  - Dry skin lotions
  - Towels
  - Washcloths
  - Brush and/or comb
  - Laundry and Housekeeping services

The CRCF must provide a private area for use by SCDHHS personnel to either conduct an assessment or interview of the resident's need for OSCAP services.

The CRCF must designate, in writing, an individual currently licensed by the South Carolina Board of Examiners for Long Term Health Care Administrators to serve as a full time facility administrator and an administrator's designee. The CRCF must notify SCDHHS within 10 business days in the event of a change in the administrator, address, phone number, or an extended absence of the administrator.

The CRCF must designate, in writing, the organizational structure, administrative control, and line of authority for

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

OSCAP Provider Responsibilities (Cont'd.)

the delegation of responsibility for every level of service delivery. This documentation must be readily accessible to all SCDHHS staff and must include an organizational chart.

The CRCF must maintain liability insurance to protect all paid and volunteer staff, including board members, from liability incurred while acting on behalf of the CRCF during the life of the OSCAP contract. The CRCF must furnish a copy of the insurance policy to SCDHHS upon request.

The CRCF must ensure that the facility administrator or designee, the CRCF Nurse, and business office manager, when applicable, are available during compliance review audits conducted by SCDHHS and/or its agents.

The OSCAP provider must employ or contract with a licensed nurse. It is the provider's responsibility to ensure the nurse is in good standing with the South Carolina Board of Nursing.

The CRCF is responsible for ensuring that resident to staff ratios are congruent with SCDHEC regulation at all times.

The CRCF must ensure that all persons with access to confidential information regarding the beneficiaries are informed of Health Insurance Portability and Accountability Act (HIPAA).

The provider must maintain an accurate daily census report that accounts for all facility residents, regardless of pay source. The daily census report must be available to SCDHHS representatives upon request.

The CRCF must make available all resident and personnel records, including financial records regarding beneficiaries' personal needs allowance, to any SCDHHS staff member 24 hours a day, seven days a week.

OSCAP services must be authorized and performed by CRCF staff to be eligible for reimbursement. The services provided to each participant are dependent upon his or her needs.

The provider's resident assistants must assist the participant according to their level of care and functional /cognitive deficits as specified in the participant's service plan, individual care plan, and OSCAP task log:

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

OSCAP Provider Responsibilities (Cont'd)

- Responding according to symptoms
- Reporting changes in resident's condition to the appropriate authorities

OSS and OSCAP Background Checks

A criminal background check is required for all potential employees prior to employment then every 5 years thereafter. This would include: direct care staff, administrative employees, and all manager positions.

All criminal background checks must be kept in the employees personnel file.

Potential employees with felony convictions within the last 10 years cannot provide administrative support/services to SCDHHS participants.

Hiring of employees with misdemeanor convictions will be at the provider's discretion. Potential employees with non-violent felony convictions dating back 10 or more years or misdemeanors can provide services to SCDHHS participants under the following circumstances:

- Providers must notify the participant and/or responsible party of the resident assistant's criminal background, *i.e.,* felony conviction, and year of conviction.
- Providers must obtain a written statement, signed by the participant and/or responsible party acknowledging awareness of the resident assistant's criminal background and agreement to have the assistant provide care. This statement must be placed in the participant record.
- Potential administrative or office employees with non-violent felony convictions dating back 10 or more years can work in the – facility at the provider's discretion.

OSS and OSCAP Facility Administrator

The CRCF must have on staff a facility administrator currently licensed by the South Carolina Board of Examiners for Long Term Health Care Administrators. This person will employ qualified personnel and ensure adequate staff education, in-service training, conduct employee evaluations, and supervise resident assistants, or designate a staff member to supervise resident assistants. A posted schedule must be maintained reflecting the hours the administrator is in the building.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

OSS and OSCAP Facility Administrator (Cont'd.)

The facility administrator must ensure that at least one direct care staff with certification in First Aid and cardiopulmonary resuscitation (CPR) is in the facility at all times.

When supervision is to be provided by an individual other than the CRCF administrator, that person is trained by the CRCF nurse to supervise the OSCAP service delivery and that person has been determined by the CRCF nurse to be competent and capable of performing the daily on-site supervision and monitoring function. The CRCF must identify the position and qualifications of the individual who will provide the daily supervision of unlicensed resident assistants. Documentation of the CRCF Nurse's delegation to the supervising staff must be available in the staff's personnel record.

OSS AND OSCAP STAFF REQUIREMENTS

No direct care staff or nurse will perform any service related to OSCAP while on duty at any other health care entity. Any substantial finding that a violation has occurred will be reported to the Board of Nursing, Board of Long Term Health Care Administrators, and the Bureau of Long Term Care Certification.

For facilities with residents housed in detached buildings or units, there must be at least one qualified and trained direct care staff present and available in each building or unit when residents are present in the building or unit. There must be at least one direct care staff member on duty for each eight residents during all periods of peak hours (7:00 am – 7:00 pm.)

CRCF facilities having eight residents or less must have at least one or more qualified and trained direct care staff, immediately available, in the facility during resident sleeping hours (7:00 pm – 7:00 am). CRCF facilities with nine residents or more must have qualified and trained direct care staff awake and on duty in the facility during resident sleeping hours. If any resident has been assessed as having night needs or is incapable of calling for assistance, staff must be awake and on duty.

There must be at least one night staff person awake and on duty if any resident with dementia is determined through a pre-admission assessment, reassessment, or observation to

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PROGRAM SERVICES

OSS AND OSCAP STAFF REQUIREMENTS (CONT'D.)

require awake night supervision. This also applies to residents who require supervision and/or monitoring due to being a danger to themselves or others.

OSCAP Resident Assistants

Providers will employ resident assistants who meet the following minimum qualifications:

- Able to read, write, and communicate effectively with participant and supervisor
- Capable of assisting with the activities of daily living
- Capable of following a care plan with minimal supervision
- Be at least 18 years of age
- Have successfully completed a competency training and evaluation program performed by a licensed nurse prior to providing services to participants. The competency evaluation must contain all elements of the OSCAP services. The competency training must also include training on appropriate record keeping and ethics and interpersonal relationships. Training documents must be signed and dated by the trainee and trainer. All signatures must be original. Signature stamps are not acceptable.
- Proof of the competency evaluation must be recorded and filed in the personnel record prior to the resident assistant providing care to participants. The Annual Competency Evaluation Documentation form can be found in the Forms section of this manual.
- All assistants, including those who are certified nursing assistants (CNAs), are required to complete the competency testing or training and evaluation outlined above annually.
- All resident assistants must have a minimum of 6 hours relevant in-service training per calendar year, in addition to DHEC required training. Documentation must include topic, name and title of the trainer, training objectives, outline of content, length of training, list of trainees, and location. Training topic examples are in the Forms section of this manual.

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PROGRAM SERVICES

OSCAP Resident Assistants (Cont'd.)

Note: The annual 6-hour training requirement will be on a pro-rated basis during the resident assistant's first year of employment.

OSCAP CRCF Nurse

Providers must employ or contract with a licensed nurse currently licensed by the South Carolina State Board of Nursing.

Providers must verify nurse licensure at the time of employment and will ensure that the license remains active at all times during employment. Providers must maintain a copy of the current license in the employee's personnel file. Nurse licensure can be verified at the Labor, Licensing and Regulation website: www. llronline.com

SCDHHS must be notified in writing by the licensee within 10 days of any change in the CRCF nurse or extended absence of the nurse. The notice must include at a minimum the name of the newly appointed individual, the effective date of the appointment, and a copy of the nurse's license. The facility must not be without nursing coverage for more than 90 days.

Duties of the OSCAP CRCF Nurse

The CRCF must maintain the necessary arrangements to have:

- A licensed nurse available for consultation with the SCDHHS representatives upon request.
- A Licensed nurse available to the CRCF staff.
- The individual care plan (ICP) must be reviewed signed and dated at initiation of services, as changes occur but at a minimum at least every six months.
- The initial Monthly Task Log must be created by the CRCF licensed nurse. The CRCF nurse must review, revise, sign and date each monthly task log at least every 90 days.
- The CRCF nurse is responsible for providing and/or coordinating competency training to the administrator and direct care staff. CRCF nurse must review, sign and date documentation once completed.

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Duties of the OSCAP CRCF Nurse (Cont'd.)

- The staff person responsible for supervision of direct care staff must be trained and determined competent and capable by the CRCF nurse.
- Complete an initial summary and quarterly summary thereafter for each OSCAP participant. The summaries are to be completed following a face to face evaluation of the beneficiary. The summaries must include: vitals, weight, functional/cognitive dependencies, any behavioral problems, and medical complications. The summaries must be written, signed and dated by the CRCF nurse.
- All CRCF nurses are required to attend any scheduled OSCAP trainings or meetings provided by SCDHHS.

OSCAP Staff Training

In addition to the DHEC requirements, all CRCF staff members providing OSCAP direct care must have a minimum of 6 hours relevant in-service training per calendar year. (The annual six-hour requirement will be on a pro-rated basis during the assistant's first year of employment.) In-service training is in addition to the competency evaluation completed by the CRCF nurse. Documentation must include topic, name and title of trainer, training objectives, outline of content, length of training, list of trainees, and location. In-service training may be furnished by the CRCF nurse while the staff person is furnishing care to the participant.

Documentation of orientation and in-service training must be signed and dated by both the individual providing the training and the individual receiving the training. The facility must document in personnel files that each employee has completed required orientation, education, and training.

Training must be provided by appropriate resources (*e.g.*, licensed and/or registered persons, video tapes, books, etc.) to all staff members, direct care volunteers, and private sitters in the context of their job duties and responsibilities. Training must be provided prior to contact with the participant and annually thereafter, unless otherwise specified by the certificate.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

OSCAP Staff Training (Cont'd.)

The following training must be administered to all individuals who have direct contact with the participant:

- Depending on the type of residents, care of persons specific to the physical and/or mental condition being cared for in the facility (*e.g.,* Alzheimer's Disease and/or related dementia, cognitive disability, etc.) to include communication techniques (cueing and mirroring), understanding and coping with behaviors, safety, activities, etc.
- Preventing and reporting abuse, neglect, or exploitation of a vulnerable adult
- Assisting residents with activities of daily living (ADL's) including dressing, transferring, ambulation, bathing, grooming, toileting, eating, and urinary or bowel incontinence care
- Ethics and interpersonal relationships

Additional topics for consideration can be found in the document entitled *Potential In-service Topic List* in the Forms section of this manual.

OSCAP Competency Evaluation

Every employee providing direct care or supervising those who provide direct care must complete an initial competency evaluation as a part of the orientation process, and annually thereafter. It is the responsibility of the CRCF administrator to ensure that resident assistants and the supervising staff are competent to perform the tasks identified in the individual care plan. The facility administrator and/or any staff person with daily supervisory responsibilities for resident assistants must complete the required competency evaluations annually. The annual competency evaluation is in addition to the training requirements of DHEC and six hours of in-service training mentioned below. All competency evaluations must be signed by a licensed nurse. The competency evaluation form is located in the Forms section of this manual. The provider may use a form of their choice as long as all items are covered.

OSS and OSCAP Orientation

Orientation for a staff member or a volunteer must be completed within seven business days of employment or volunteer service and annually thereafter. Orientation training must include the following topics:

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

OSS and OSCAP Orientation (Cont'd.)

- The CRCF's policies and procedures
- Confidentiality of resident information and records and the protecting of resident's rights such as the Resident's Bill of Rights
- Prevention of and reporting abuse, neglect, or exploitation of vulnerable adults
- Infection control including hand washing, linen handling, and prevention of communicable diseases
- Fire safety, emergency procedures, and disaster preparedness within 24 hours of their first day on the job in the facility and annually thereafter

CONDUCT OF SERVICE

OSCAP services must be authorized, delivered and appropriately documented to be eligible for reimbursement. The services provided to each participant are dependent upon the individual resident's needs as set forth in a service plan.

OSS and OSCAP Written Agreement

The facility must maintain a copy of the written agreement, as required by current state regulation, between the resident, responsible party (as necessary), and the facility.

The agreement must include at least the following:

1. An explanation of the specific care, services, and equipment provided by the facility, e.g., administration of medication, provision of special diet as necessary, assistance with bathing, toileting, feeding, dressing, and mobility
2. Disclosure of fees for all care, services, and equipment provided
3. Advance notice requirements to change fee amount
4. Refund policy to include when monies are to be forwarded to resident upon discharge, transfer, or relocation
5. The date a resident is to receive the personal needs allowance
6. Transportation policy
7. Discharge and transfer provisions; including the conditions under which the resident may be discharged and the agreement terminated, and the disposition of personal belongings.

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OSS and OSCAP Written Agreement (Cont'd.)

8. Documentation of the explanation of the Resident's Bill of Rights and the grievance procedure.

Care, services, and items provided by the facility, the charges, and those services that are the responsibilities of the resident must be delineated in writing. The resident must be made aware of the charges and/or services. Also, any changes to the charges and/or services must be acknowledged by the resident or responsible party as evidence by his/her signature and date.

OSCAP Assessment

The SCDHHS Nurse assesses each applicant utilizing a comprehensive standard instrument to determine his or her medical needs and appropriate services. The assessment will be used to make the medical necessity determination, and provide accurate information for the CRCF nurse to use in developing the individual care plan.

The medical necessity determination is the process of identifying the extent of a person's functional dependencies and cognitive impairments in keeping with the South Carolina Level of Care Criteria for Long Term Care. By applying specific measures regarding functioning and cognition levels of the resident, the resident's need for OSCAP service is determined.

As part of the assessment, the SCDHHS nurse will interview the resident, review the medical records, consult with CRCF staff and the CRCF nurse, and may consult with the resident's physician, or a responsible party.

OSCAP Service Plan

The Service Plan must be individualized for each participant and completed so that a service professional unfamiliar with the participant can have, by reading the plan, a clear picture of the participant's needs, strengths, preferences, planned interventions, and person(s) performing the interventions. It is a document that directs the provision of OSCAP services.

The Service Plan, developed by the SCDHHS Nurse, is based on a SCDHHS assessment of functional dependencies and cognitive impairments of the resident. A copy of the most current Service Plan must be maintained in the participant's record, and be available for review by a SCDHHS representative upon request.

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PROGRAM SERVICES

Service OSCAP Authorization/ Status Form

The provider must have a service authorization issued by the SCDHHS nurse prior to providing OSCAP services to a resident. A copy of the most current service authorization must be kept in the participant's record or file.

OSS and OSCAP Individual Care Plan

The provider will develop and maintain an Individual Care Plan (ICP) for each resident per current state regulations pertaining to CRCF's. For OSCAP participants, the ICP must be updated to reflect the resident's status in OSCAP.

For OSCAP participants, the ICP must be reviewed, updated (if appropriate), signed and dated by the CRCF nurse at least every six months, or as changes in residents' needs occur if more frequent than six months. The facility administrator and staff members responsible for implementing the ICP must meet with the CRCF nurse during, or after, each six month review or revision. During this meeting, the resident's condition, appropriateness of the ICP, and any changes in service needs must be discussed.

The ICP documentation on file must include:

- The needs of the resident, including the activities of daily living for which the resident requires assistance, (*i.e.*, what assistance, how much, who will provide the assistance, how often, and when) in addition to specific functional and cognitive propensities and how these will be monitored and/or addressed.
- Requirements and arrangements for visits by or to physicians or other authorized health providers. An authorized healthcare provider is an individual authorized by law and currently licensed in South Carolina to provide specific treatments, care, or services to residents. Examples of individuals who may be authorized by law to provide the aforementioned treatment/care/services may include, but are not limited to, advanced practice registered nurses, physician's assistants, social workers, certified nursing assistants, etc.
- Advanced care directives/healthcare power-of-attorney, as applicable

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

OSS and OSCAP Individual Care Plan (Cont'd.)

- Recreational and social activities which are suitable, desirable, and important to the well-being of the resident
- Dietary needs

The ICP must be individualized for the particular resident whose needs it is designed to meet. It must be completed in such a way that the resident assistant caring for the participant will have a clear picture of the assistance needed by the resident. The ICP is to direct the services provided to the resident and the OSCAP task log.

For OSCAP participants, the ICP must be signed and dated by the resident, administrator, responsible party when appropriate, and the CRCF Nurse.

ICPs must be re-developed at least every 24 months from the date of the initial ICP. Re-developed ICPs must contain all required signatures and dates. All ICPs must be maintained in the resident's permanent record, and must be available for a DHHS representative to review upon request.

OSCAP Task Log

The provider must complete and maintain OSCAP task logs for each OSCAP participant in the CRCF. The care outlined on the task logs must be supported by the OSCAP Service Plan and the ICP. The OSCAP task log can be found in the Forms section of this manual.

OSCAP task logs must be completed daily by the resident assistant rendering services. The facility administrator (or designee) must review them weekly and sign-off on their accuracy and completion. Each completed OSCAP task log must be reviewed, signed and dated at least every 90 days by the CRCF nurse, for verification of completion and relation to the ICP. (Instructions for completing the OSCAP task log can be found in the Forms section of this manual.)

Providers must maintain at least 12 months of each participant's OSCAP task logs in the participant's file or record.

All OSCAP task logs must be available for review by a SCDHHS representative upon request. Payment for OSCAP services will be recouped if the service is not delivered and documented as required.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

OSCAP Activities and Recreation

The OSCAP provider will provide a broad assortment of regularly scheduled, purposeful activities, including recreational, spiritual, education, social, craft, and work oriented activities.

At least one staff person must be trained and responsible for providing and coordinating recreational activities for the residents. Prior to contact with residents, the staff person must have appropriate training, and at least annually thereafter. Documentation of staff training for providing/coordinating recreational activities must be maintained.

There must be at least one different structured recreational activity provided daily each week that must accommodate residents' needs, interests, and capabilities as indicated in the ICP.

The facility must designate a staff member responsible for the development of the recreational program, to include responsibility for obtaining and maintaining recreational supplies. The recreational supplies must be adequate and must be sufficient to accomplish the activities planned.

A current month's schedule must be posted in order for residents to be made aware of activities offered. This schedule must include activities, dates, times, and locations. The up-to-date calendar must be large enough for persons with vision difficulty to see, posted in conspicuous places, and in view of all residents. Monthly calendars must also be posted in the residents' rooms.

OSCAP SERVICE ADMINISTRATION

CRCF Policy and Procedure Manual — OSCAP

Providers must maintain a section in its existing policy and procedure manual describing the provision of OSCAP services. The OSCAP section must set forth the policies and procedures as outlined in the OSCAP contract and this provider manual. This section must be utilize to ensure compliance with South Carolina Department of Health and Human Services.

The OSCAP section must include the provider's emergency plan and quality improvement program in accordance with DHEC regulation 25A S.C. Code Ann.

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PROGRAM SERVICES

CRCF Policy and Procedure Manual — OSCAP (Cont'd.)

Regs. (Supp. 2010). Providers must amend their policies and procedures as necessary or upon request of an OSCAP program coordinator.

The OSCAP section of the CRCF's policy and procedure manual must be available for review by any SCDHHS representative.

The following components must be included in the OSCAP section of the CRCF's policy and procedures manual:

1. **ICP Development and Approval Process:** This component must include the process used to determine services provided by the facility in accordance with the Service Plan. The responsibilities of the CRFC nurse and other staff in the process must be documented, as well.
2. **Staff Training:** This component states the content of staff training and must include documentation of required training received by facility staff, including orientation and in-service training.
3. **Licensed Nurse Requirements:** This component is the policy for maintaining the necessary arrangements to have a licensed nurse. The policy and procedures will reflect the relationship with the provider and the role of the nurse in the facility.
4. **Daily Census:** This component includes documenting the daily census of all residents, regardless of pay source. The documentation must include identifiers for OSCAP participants and specify whether the participant was on medical or non-medical bed hold, admitted or discharged on that date, or was transported for emergency treatment.
5. **Facility Inspection Plan:** This component ensures the CRCF posts the most recent and comprehensive general inspection report and the CRCF's response. The posting location in the facility must be specified in the plan. The posting location must be in an easily accessible area to participants and in a prominent area for visitors to review. Subsequent complaint inspection reports and the CRCF's responses must be posted as well.

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PROGRAM SERVICES

CRCF Policy and Procedure Manual — OSCAP (Cont'd.)

- **Emergency Preparedness Plan:** This component describes the CRCF's actions during an emergency situation. A sheltering agreement is required by licensing regulations and must be included in the plan.
- **Backup Service Provision – Staff:** This component describes the provision for acquiring additional staff support in the event of unexpected facility situation.
- **Grievance and Complaint Process:** This component provides an opportunity for participants to document their dissatisfaction with services provided by the CRCF. This process enforces the Resident's Bill of Rights, which includes, at a minimum, the address and phone number of the following entities:
    - SCDHEC Division of Health Licensing
    - SCDHHS Division of Long Term Care Transformation
    - South Carolina Regional Long Term-Care Ombudsman
    - The local Adult Protective Services

  Note: The documentation must include a provision prohibiting retaliation against participants must a grievance be filed against the CRCF.

OSS and OSCAP CRCF Quality Improvement Program

The provider must have a written, implemented quality improvement program that provides effective self-assessment and implementation of changes designed to improve the care and service provided by the facility. The quality improvement program must meet the requirements specified in DHEC regulation 25A SC Code Ann. Regs. §61-84 (Supp. 2010) and as outlined in this manual.

The CRCF must have a Quality Assurance/Improvement Committee that meets at least quarterly to monitor trends and customer satisfaction and document quality assurance efforts and outcomes. The committee must include the OSCAP CRCF nurse, the administrator, a direct care staff member or person responsible for administering medications, and a pharmacist consultant if a medication

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

OSS and OSCAP CRCF Quality Improvement Program (Cont'd.)

problem is to be monitored or investigated. The minutes of all Quality Assurance/Improvement meetings must be made available to SCDHHS representatives upon request.

The provider will be required to complete and submit Quality Assurance documentation, including self-reports and evaluations and OSCAP required reports, reviews and audits, as requested. The quality assurance documentation may encompass reviews of any aspect of service delivery by the provider and is inclusive of access to policies, consumer records and other materials as may be necessary. Reviews and reports may involve discussions with:

- The provider's administrative personnel and direct care staff
- The participant, their representative(s), family and friends
- Participant advocates
- Community organizations and other service providers for the participant
- Legal authorities
- Other persons and organizations, as SCDHHS may determine are appropriate

Residential Personal Care Service

The objective of Residential Personal Care (RPC) services is to restore, maintain, and promote the health status of Medicaid Home and Community Based waiver participants who choose to transition from their homes into an enrolled RPC community residential care facility of their choice or for individuals who wish to remain in his/her enrolled RPC community residential care facility of choice and meet the intermediate nursing home level of care.

SCDHHS has amended its Community Choices waiver to create a second tier for OSCAP services. This second tier waiver service will provide a higher level of personal care services for CRCF residents with intermediate nursing facility level of care. This new waiver service will be funded at regular service match rates by Medicaid.

Residential Personal Care Providers must have all of the following qualities as outlined in the 42 CFR 441.301(c)(4-5).

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PROGRAM SERVICES

Residential Personal Care Service (Cont'd.)

CFR 441.301(c)(4)
Home and Community-Based Settings

Home and community-based settings must have all of the following qualities, and such other qualities as the Secretary determines to be appropriate, based on the needs of the individual as indicated in their person-centered service plan:

(i) The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

(ii) The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.

(iii) Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.

(iv) Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.

(v) Facilitates individual choice regarding services and supports, and who provides them.

(vi) In a provider-owned or controlled residential setting, in addition to the qualities at §441.301(c)(4)(i) through (v), the following additional conditions must be met:

(A) The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Residential Personal Care Service (Cont'd.)

individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the State must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.

(B) Each individual has privacy in their sleeping or living unit:

1) Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors.
2) Individuals sharing units have a choice of roommates in that setting.
3) Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.

(C) Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time.

(D) Individuals are able to have visitors of their choosing at any time.

(E) The setting is physically accessible to the individual.

(F) Any modification of the additional conditions, under §441.301(c)(4)(vi)(A) through (D), must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan:

1) Identify a specific and individualized assessed need.

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PROGRAM SERVICES

Residential Personal Care Service (Cont'd.)

2) Document the positive interventions and supports used prior to any modifications to the person-centered service plan.

3) Document less intrusive methods of meeting the need that have been tried but did not work.

4) Include a clear description of the condition that is directly proportionate to the specific assessed need.

5) Include regular collection and review of data to measure the ongoing effectiveness of the modification.

6) Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.

7) Include the informed consent of the individual.

8) Include an assurance that interventions and supports will cause no harm to the individual.

CFR 441.301(c)(5)
Settings that are not Home and Community-Based

Home and community-based settings do not include the following:

(i) A nursing facility;

(ii) An institution for mental diseases;

(iii) An intermediate care facility for individuals with intellectual disabilities;

(iv) A hospital; or

(v) Any other locations that have qualities of an institutional setting, as determined by the Secretary. Any setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment, or in a building on the grounds of, or immediately adjacent to, a public institution, or any other setting that has the effect of isolating individuals receiving

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Residential Personal Care Service (Cont'd.)

Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS will be presumed to be a setting that has the qualities of an institution unless the Secretary determines through heightened scrutiny, based on information presented by the State or other parties, that the setting does not have the qualities of an institution and that the setting does have the qualities of home and community-based settings.

OSS AND OSCAP INCONTINENCE SUPPLIES

Incontinence supplies are diapers, underpads, wipes and liners provided to participants who are at least 21 years old and who are incontinent of bowel and/or bladder according to the established medical criteria.

Medical Necessity Criteria

The following criteria must be met for beneficiaries to receive incontinence supplies:

1. Must be a Medicaid beneficiary age four or above
2. Inability to control bowel or bladder functions; this must be confirmed by a physician in writing.
3. An order must be obtained from the primary physician that the beneficiary is incontinent. The Physician Certification of Incontinence DHHS form 168IS must be completed by the primary physician initially and every 12 months at a minimum for waiver beneficiaries. Certifications for non-waiver beneficiaries are effective for timeframes of three months, six months, nine months or 12 months.

Authorization/Frequency

Authorization of diapers/pull-ups and underpads for adults (age 21 and older) must be based on frequency of incontinence as follows:

1. Occasionally incontinent allows up to one case per quarter. For bladder-indicates two or more times a week but not daily. For bowel-indicates once a week.
2. Frequent incontinence allows up to two cases every quarter. For bladder-indicates daily incontinence, but some control, OR if the beneficiary is being toileted (extensive assistance) on a regular basis, i.e. every two hours.

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PROGRAM SERVICES

Authorization/Frequency (Cont'd.)

3. Total incontinence allows one case per month. Indicates total incontinence and no control (or an indwelling catheter or ostomy that controls the beneficiary's bladder or bowel).

The Medicaid State Plan covers the following based on medical necessity:

- One case of diapers or briefs (one case = 96 diapers or 80 briefs)
- One case of incontinence pads/liners [one case = 130 pads]
- One case of underpads
- One box of wipes

Note: If the beneficiary has an ostomy or catheter for urinary control and an ostomy for bowel control, no diaper or pull-ups will be authorized, but under pads may be authorized. If the beneficiary has an appliance for bowel or bladder control, but not both, diapers/pull-ups may be authorized based on the frequency of incontinence.

Authorization of wipes is based on an incontinence need and the beneficiary must receive diapers/pull-ups and/or underpads to receive wipes. The frequency will be determined by the assessment conducted by the nurse; however the maximum allowed is one box per month for adults (age 21 and older).

Note: For those beneficiaries enrolled in a South Carolina Department of Disabilities and Special Needs (SCDDSN) waiver, the service coordinator/case manager will conduct the assessment to determine the frequency of incontinence supplies authorized and obtain the Physician Certification of Incontinence DHHS Form 168IS from the primary physician initially and every 12 months at a minimum.

Physician Certification Requirement for Incontinence Supplies

Effective July 1, 2014, incontinence supply providers will be responsible for obtaining the Physician Certification of Incontinence SCDHHS Form 168IS prior to delivering Incontinence supplies.

The Physician Certification of Incontinence SCDHHS form 168IS is mandatory for all beneficiaries receiving incontinence supplies as a State Plan Home Health benefit. The form must be completed by the primary care physician

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Physician Certification Requirement for Incontinence Supplies (Cont'd.)

both initially and at every certification period as selected by the primary care physician. The primary care physician information is gathered at intake once the referral is made to Community Long Term Care (CLTC) centralized intake.

Non-Waiver CRCF beneficiaries have certification periods of three months, six months, nine months or 12 months and the certification period is determined by the primary care physician.

The incontinence supply provider must send the form to the primary care physician to complete. The provider must not give the form to the beneficiary to take to their physician and Medicaid prohibits incontinence supply providers from preparing the entire Physician Certification of Incontinence SCDHHS 168IS.

The primary care physician will complete the following sections on the SCDHHS FORM 168IS: the checkboxes for incontinence of bowl or bladder, the certification periods, the diagnosis related to incontinence, usage of appliances, any comments and the checkboxes for medical necessity. The form must be fully completed. The physician's signature and date fields must be completed by the primary care physician; nurse practitioner and physician assistant signatures are not acceptable.

The Physician Certification of Incontinence DHHS form 168IS will expire if not completed, signed, and dated by the primary physician every three months, six months, nine months or 12 months for non-waiver beneficiaries and every 12 months for waiver beneficiaries. Expiration of the Physician Certification of Incontinence DHHS Form 168IS means the beneficiary will no longer meet the medical necessity criteria to receive incontinence supplies under the State Plan Home Health Benefit

Referrals

Referrals for incontinence supplies can be made to the Division of Community Long Term Care (CLTC) centralized intake by one of the methods below:

- Electronic (Preferred Method) https://phoenix.scdhhs.gov/cltc_referrals/new
- Telephone: 888-971-1637
- Mail: South Carolina DHHS

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PROGRAM SERVICES

Referrals (Cont'd.)

Community Long Term Care
Intake-J9
PO Box 8206
Columbia, SC 29202-8206

Process

Once a beneficiary is determined eligible for incontinence supplies, by meeting the medical necessity criteria and a phone assessment has been conducted through CLTC centralized intake to determine the frequency of incontinence and the amount of supplies authorized, a provider choice form will be sent to the beneficiary to select a provider to receive the incontinence supplies from. The SCDHHS nurse will monitor periodic recertification for incontinence supplies per beneficiary with the Physician Certification of Incontinence DHHS Form 168IS on file every 12 months at a minimum for waiver beneficiaries. Certifications for non-waiver beneficiaries are effective for timeframes of three months, six months, nine months or 12 months and are based on the selection chosen by the physician.

Authorizations for incontinence supplies will be made through the SCDHHS Phoenix web-based case management and authorization system. This system notifies the provider with an email directing the provider to a secure website. All providers requesting enrollment as an incontinence provider to distribute incontinence supplies must be trained and utilized the Phoenix web-based case management and authorization system. Please refer to the Community Long Term Care (CLTC) provider manual for more information on provider enrollment and incontinence supply reimbursement.

Note: South Carolina Department of Disabilities and Special Needs (SCDDSN) does not currently participate in the Phoenix web-based authorization system. Service coordinators/case managers will send authorizations and terminations to providers for incontinence supplies for beneficiaries in the CS, HASCI and ID/RD waivers.

Services not covered by the Medicaid Home Health program include:

- Services not reasonable and necessary for diagnosis or treatment of illness or injury
- Full-time nursing care

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PROGRAM SERVICES

Process (Cont'd.)

- Drugs and biologicals
- Meals delivered to the home
- Homemaker services
- Care primarily for treatment of mental diseases
- Separate medical rehabilitation facilities
- Routine supplies
- Supervisory nurse visits

Incontinence Supply Record Maintenance

Upon SCDHHS authorizing incontinence supplies, a Long Term Care Notification Form is mailed to the resident or responsible party, which indicates the incontinence supplies authorized as well as the provider. The CRCF must obtain a current copy of the Long Term Care Notification Form for each resident receiving incontinence supplies and maintain the form in each resident's medical record.

The CRCF must also obtain a delivery receipt or shipping receipt of every delivery for each resident receiving incontinence supplies each month. A copy of the receipt documentation must be maintained in the resident's medical record for at least 12 months and made available for SCDHHS staff upon request.

The resident's Individual Care Plan must reflect the resident's need for incontinence supplies, including frequency, supplies used, and updated according the changes.

The resident's progress notes must reflect frequency and changes in Incontinence needs.

Incontinence supplies must be labeled for individual use, and stored in each resident's room (if space permits).

The facility may keep them in alternate storage if the resident's room does not provide for adequate storage space. If supplies are stored in a common storage room/closet the facility must:

- Store the incontinence supplies in a secured area which is available to residents as needed
- Label each individual's supplies for his/her use only

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Incontinence Supply Record Maintenance (Cont'd.)

- An inventory accounting for each individuals supplies use must be maintained for each month. A copy of each monthly inventory accounting must be maintained in the resident's medical record for one year (12 months), and available for SCDHHS staff upon request.

Incontinence Supplies Sanctions

Failure to follow these policies and procedures could result in immediate sanctions imposed by SCDHHS. SCDHHS sanctions are described later in this provider manual.

In instances where potential fraud of Incontinence Supply service is suspected, a referral to the SCDHHS Division of Program Integrity (PI) will be made. The Division of Program Integrity carries out SCDHHS responsibilities concerning suspected Medicaid fraud. Suspected cases of Medicaid fraud by health care providers are referred to the Medicaid Fraud Control Unit (MFCU) of the State Attorney General's Office for investigation and possible prosecution.

OSS/OSCAP Compliance Reviews

SCDHHS reserves the right to perform on-site compliance reviews during normal business hours to ensure compliance with policies and procedures, state and federal enrollment requirements, and to verify the accuracy of the information submitted to SCDHHS. Providers must permit SCDHHS, its agents or designated contractor, to conduct announced or unannounced on-site inspections of all of provider's locations. Any enrolling and/or enrolled providers that fail to permit access for on-site visits will be denied enrollment or terminated from OSS/OSCAP.

The purpose of this on-site review is to establish that the provider meets the requirements specified in this Manual and as outlined in the Facility Participation Agreement, ensure required documentation is in place to support claims filed to SCDHHS and verify the accuracy of the information submitted to SCDHHS. The compliance review and sanction scoring process is designed to ensure that reviews are equitable, understandable, and respectful of quality care and services.

All OSS/OSCAP service providers receive a Compliance Review to ensure that adequate and appropriate services are provided in compliance with applicable requirements.

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OSS/OSCAP Compliance Reviews (Cont'd.)

The process includes a scoring system whereby providers can achieve one of the following levels:

- Substantial
- Partial
- Minimal
- Non-compliance

Level of Compliance and Review Cycle

Compliance Reviews are generally scheduled every 18 months. A Compliance Review instrument will be utilized to determine a provider's compliance. The score received during an on-site review determines the frequency and schedule of the subsequent reviews. A calculation for each area of service delivery and service management determines the score.

The following table shows the level of compliance and review cycle scoring system.

Level Of Compliance And Review Cycle Scoring System

Compliance Score	Level of Compliance	Next Review
3.26 – 4.00	Substantial	12-15 months
2.51 – 3.25	Partial	9-12 months
1.76 – 2.50	Minimal	6-9 months
0.00 – 1.75	Non-compliance	3-6 months

Technical Assistance

SCDHHS will address the technical assistance needs of the CRCF with special emphasis on compliance. OSS/OSCAP staff will accomplish this by empowering providers, in an atmosphere of cooperation and partnership, to make positive, permanent changes that will ultimately improve services to patients. Specifically, OSS/OSCAP staff seeks to:

- Identify service providers in need of technical assistance, through assessment of service provider compliance levels, and requests for technical assistance
- Conduct on-site assessments, provide educational

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PROGRAM SERVICES

Technical Assistance (Cont'd.)

interventions and follow-up visits to all CRCFs which are experiencing difficulty maintaining satisfactory compliance levels

- Establish positive working relationships with service providers so that necessary knowledge and skills will be effectively transferred
- Develop action plans, which clearly detail the objectives to be accomplished in the appropriate timeframes; and formulate sample record and management forms and procedures that can be adapted by service providers to meet basic compliance requirements.

SANCTIONS

In the event SCDHHS finds the provider to be out-of-compliance with program standards, performance standards, or the terms or conditions of the OSCAP contract, SCDHHS must have the right to exercise any of the sanction options described in this Manual or as outlined in the OSCAP Contract, in addition to any other rights and remedies that may be available to SCDHHS.

The type of action taken must be in relation to the nature and severity of the deficiency *i.e.,* the offense will determine the sanctioning level.

SCDHHS may initiate a sanction immediately if it is determined that the health, safety, or welfare of a participant is endangered, for potential fraud, or for quality-of-care issues.

Failure to impose a sanction for a contract violation does not prohibit SCDHHS from exercising its right to do so for subsequent contract violations.

This section describes the SCDHHS levels of sanctioning for CRCFs. A combination of sanctions may be imposed.

CORRECTIVE ACTION PLAN (CAP)

This is the lowest sanction and indicates the provider is in substantial compliance with the contractual requirements. The provider will be required to submit a corrective action plan within 30 days outlining how deficiencies will be corrected (or have been corrected) and how they will avoid future deficiencies. An implementation date must be indicated.

Providers failing to submit the CAP within 30 days will

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CORRECTIVE ACTION PLAN (CAP) (CONT'D.)

automatically move to the suspension level described below. This sanction will be imposed until the facility develops and adheres to a corrective action plan to adequately address these concerns.

Suspension

At this level, new referrals and admissions will be suspended for a minimum of 30 days. A written CAP addressing deficiencies must be submitted to SCDHHS within 15 days from the start of the suspension. SCDHHS will review the CAP to determine if the response is acceptable. If the CAP is not acceptable, clarification of additional information will be requested. This suspension will be lifted when a corrective action plan (15 days from receipt of an acceptable CAP) is submitted and found to be acceptable. A suspension lasting more than 90 days will result in termination.

This sanction is the denial of payment for new admissions and readmissions and will be imposed if the provider:

- Has multiple substantiated complaints within a twelve month time period submitted to SCDHHS and/or from various agencies such as Long Term Care Ombudsman, Protection & Advocacy, DHEC, etc., related to the physical conditions and/or quality of care in the CRCF

A Compliance review score reflecting minimal to partial compliance according to the compliance review and sanction scoring process. This sanction will be imposed until the facility develops and adheres to a corrective action plan to adequately address these concerns, and a compliance review is conducted by a SCDHHS representative(s).

Directed In-Service Training

This sanction will be imposed to address a pattern of deficiencies that can be corrected by educational training. For this sanction, the facility staff is required to attend in-service training program(s) as designated by SCDHHS to achieve and maintain compliance with program policies.

Prepayment Review

This sanction will be imposed for providers who have deficiencies with completing required documentation to support the claim(s) filed to SCDHHS. Providers selected for prepayment review will be required to submit

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PROGRAM SERVICES

Prepayment Review (Cont'd.)

documentation to support claims submitted. The documentation will be reviewed for completeness and accuracy prior to payments being authorized. Once the provider establishes correct billing and documentation for 3 consecutive months, prepayment review will cease.

Administrative Fines, Recoupment, Withholding and/or Offsetting

SCDHHS has the right to impose administrative fines, recoup previous payments made to the provider and/or withhold and/or offset any payments otherwise due to the provider pursuant to such sanctions and damages.

This level of sanctioning will be imposed for:

- Failure to follow the SCDHHS policies and procedures.
- Billing for more residents than the facility has licensed beds.
- Holding of OSCAP reimbursement.
- Failure to submit a Turn Around Document (TAD) for payment by the due date.
- Failure to submit monthly billing by due date.
- Failure to notify the SCDHHS eligibility worker and area SCDHHS Regional Office of admission discharges, transfers, and deaths within five business days.
- Substantiated finding of failure to follow policy for the administration of the participant's personal needs account.
- Employing an excluded individual.
- Failure to report medical or non-medical absences.

Referral to Licensing Entities and/or SCDHHS Division of Program Integrity

SCDHHS reserves the right to make referrals to South Carolina Department of Health and Environmental Control, South Carolina Board of Long Term Health Care Administrators, South Carolina Board of Nursing, and/or other licensing entities or state agencies as deemed appropriate.

In instances where potential fraud is suspected, a referral will be made to SCDHHS Division of Program Integrity. The Division of Program Integrity carries out SCDHHS responsibilities concerning suspected Medicaid fraud as

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Referral to Licensing Entities and/or SCDHHS Division of Program Integrity (Cont'd.)

well as post-payment reviews. Suspected cases of Medicaid fraud by health care providers are referred to the Medicaid Fraud Control Unit (MFCU) of the State Attorney General's Office for investigation and possible prosecution.

Instances where the facility goes through a change of ownership that has not been approved by SCDHHS which results in a sharing of OSS/OSCAP payments with a non-enrolled SCDHHS facility will be referred to SCDHHS Division of Program Integrity and/or MFCU.

Termination of OSCAP Contract

Termination means SCDHHS has taken an action to revoke a provider's Medicaid billing privileges, the provider has exhausted all applicable appeal rights or the timeline for appeal has expired, and there is no expectation on the part of the provider or SCDHHS that the revocation is temporary. Termination indicates very serious and widespread deficiencies, generally coupled with a history of substandard reviews. Termination is a last resort.

The OSCAP provider's contract will be terminated under the following conditions:

1. A Compliance review score reflecting significant deficiencies according to the compliance review and sanction scoring process, located in the OSCAP Provider Manual (as Amended).
2. DHEC Health Licensing Division sends a notice to suspend or revoke the license.
3. DHEC or law enforcement substantiates life threatening physical conditions.
4. Three suspensions with in a 24 month period.
5. Continuous substantiated complaints and/or violations of licensing regulations.

Providers must refer to Article VII, Termination of Contract, in their contract for additional conditions for termination by SCDHHS.

Provider Termination for Cause

SCDHHS will terminate the enrollment of any provider where any person with a five percent or greater direct or indirect ownership interest in the provider did not submit timely and accurate information and cooperate with any

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Provider Termination for Cause (Cont'd.)

screening methods required under 42 CFR Subpart E – Provider Screening and Enrollment.

SCDHHS will terminate the enrollment of any provider that was terminated on or after January 1, 2011, by Medicare or another State's Medicaid or Children's Health Insurance Program.

Unless SCDHHS first determines that termination is not in the best interest of the State Medicaid program and documents that determination in writing, SCDHHS will terminate a provider's enrollment for any of the following reasons:

1. Any person with a five percent or greater direct or indirect ownership interest in the provider has been convicted of a criminal offense related to that person's involvement in Medicare, Medicaid, or title XXI program in the last 10 years.
2. The provider or a person with an ownership or control interest or who is an agent or managing employee of the provider fails to submit timely or accurate information and/or does not cooperate with screening methods required by SCDHHS.
3. The provider fails to permit access to provider locations for any site visit under 42 CFR §455.432.
4. The provider fails to provide access to Medicaid patient records.
5. Any person with a 5 percent or greater direct or indirect ownership interest in the provider fails to submit sets of fingerprints in the form and manner required by SCDHHS within 30 days of a CMS or SCDHHS request.

SCDHHS may terminate a provider's enrollment for any of the following reasons:

1. It is determined that the provider has falsified any information provided on the application.
2. The identity of any provider/applicant cannot be verified.
3. The provider fails to comply with the terms of the enrollment agreement.

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Provider Termination for Cause (Cont'd.)

4. The provider fails to comply with the terms of contract with SCDHHS.
5. The provider has not repaid an outstanding debt or recoupment identified through a program integrity review.
6. The provider's license to practice has been suspended and/or revoked, or there are restrictions placed on his or her license.
7. The provider has been terminated by a Medicaid Managed Care Organization for reasons due to fraud or quality of care.
8. The provider allows a non-enrolled rendering provider to use an enrolled provider's number, except where otherwise allowed by policy.
9. The provider continues to bill Medicaid after the suspension or revocation of their medical license.
10. The provider is under a State and/or Federal exclusion.
11. The provider falsifies medical records to support services billed to Medicaid.
12. The provider is sanctioned under State Regulation 126-403.
13. The provider or any person with a five percent or greater direct or indirect ownership interest in the provider fails to submit sets of fingerprints within 30 days when required to do so.
14. Non-compliance with policies and procedures established by SCDHHS. SC Code of Regulations (126-940, (F)).
15. Additional charges to OSS recipients or family for services included in the OSS facility rate. SC Code of Regulations (126-940 (G)).

A terminated provider will be required to reapply and be re-enrolled with the Medicaid program if they wish billing privileges to be reinstated.

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Provider Appeal Rights

Providers have the right to appeal SCDHHS' action or decision in accordance with the South Carolina Code of Regulations, Chapter 126, Subarticle 3. The written notice of appeal must be received by the SCDHHS Division of Appeals and Hearings within 30 days of the written notice of SCDHHS' action or decision. The notice of appeal must specify the action/issues contested (include a copy of the action letter from SCDHHS), the jurisdictional basis of the appeal and the legal authority upon which the appellant relies.

Appeals can be submitted as follows:

- **Online at www.scdhhs.gov/appeals** or
- **Fax to:** (803) 255-8274 or (888) 835-2086
- **Mail to:**

  The Division of Appeals and Hearing
  Department of Health and Human Services
  PO Box 8206
  Columbia, SC 29202-8206
- **Email to:** eligappeals@scdhhs.gov

Please visit the following websites for more information:

http://www.scstatehouse.gov/coderegs/Ch%20126.pdf

https://msp.scdhhs.gov/appeals/

https://msp.scdhhs.gov/appeals/site-page/appeals-and-hearings-faq