

Revision: HCFA-PM-87-4 (BERC)  
MARCH 1987

OMB. No.: 0938-0193

State/Territory: South Carolina

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation  
42 CFR 431.15  
AT-79-29

4.1 Methods of Administration

The Medicaid agency employs methods of administration found by the Secretary of Health and Human Services to be necessary for the proper and efficient operation of the plan.

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TN No. MA 87-16  
Supersedes  
TN No. MA 75-06

Approval Date 10/13/87

Effective Date 07/01/87

HCFA ID: 1010P/0012P

Revision: HCFA-AT-80-38 (BPP)  
May 22, 1980

State: South Carolina

Citation  
42 CFR 431.202  
AT-79-29  
AT-80-34  
Subpart

4.2 Hearings for Applicants and Recipients

The Medicaid agency has a system of hearings that meets all the requirements of 42 CFR Part 431,  
E.

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TN No. 75-06  
Supersedes  
TN No. \_\_\_\_\_

Approval Date 08/14/75

Effective Date 04/08/75

Revision: HCFA-AT-87-9 (BERC)  
AUGUST 1987

OMB No.: 0938-0193

State/Territory: South Carolina

Citation 4.3 Safeguarding Information on Applicants and Recipients  
42 CFR 431.301  
AT-79-29

Under State statute which imposes legal sanctions, safeguards are provided that restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of the plan.

52 FR 5967 All other requirements of 42 CFR Part 431, Subpart F are met.

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TN No. MA 88-03  
Supersedes  
TN No. MA 75-6

Approval Date 07/21/88

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HFCA ID: 1010P/0012P

Revision: HCFA-PM-87-4 (BERC)  
MARCH 1987

OMB No.: 0938-0193

State/Territory: South Carolina

Citation 4.4 Medicaid Quality Control

42 CFR 431.800(c)  
50 FR 21839  
1903(u) (1) (D) of  
the Act,  
P.L. 99-509  
(Section 9407)

- (a) A system of quality control is implemented in accordance with 42 CFR Part 431, Subpart P.
- (b) The State operates a claims processing assessment system that meets the requirements of 431.800(e), (g), (h), (j) and (k).

Yes.

Not applicable. The State has an

Medicaid Management Information System (MMIS).

approved

TN No. MA 87-16  
Supersedes  
TN No. MA 78-05

Approval Date 10/13/87

Effective Date 07/01/87

HFCA ID: 1010P/0012P

Revision: HCFA-PM-88-10 (BERC)  
September 1988

OMB No.: 0938-0193

State/Territory: South Carolina

<u>Citation</u> 42 CFR 455.12 AT-78-90 48 FR 3742 52 FR 48817	4.5 <u>Medicaid Agency Fraud Detection and Investigation Program</u>  The Medicaid agency has established and will maintain methods, criteria, and procedures that meet all requirements of 42 CFR 455.13 through 455.21 and 455.23 for prevention and control of program fraud and abuse.
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TN No. MA 88-17  
Supersedes  
TN No. MA 83-07

Approval Date 01/09/89

Effective Date 01/01/89

HFCA ID: 1010P/0012P

Revision:

## STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: South Carolina**SECTION 4 - GENERAL PROGRAM ADMINISTRATION****4.5 Medicaid Recovery Audit Contractor Program**

<p>Citation</p> <p>Section 1902(a)(42)(B)(i) of the Social Security Act</p> <p>Section 1902(a)(42)(B)(ii)(I) of the Act</p> <p>Section 1902 (a)(42)(B)(ii)(II)(aa) of the Act</p>	<p><input checked="" type="checkbox"/> The State has established a program under which it will contract with one or more recovery audit contractors (RACs) for the purpose of identifying underpayments and overpayments of Medicaid claims under the State plan and under any waiver of the State plan.</p> <p><input checked="" type="checkbox"/> The State is seeking an exception to establishing such program for the following reasons:</p> <p>The State is seeking an exception to 42 CFR §455.508(b), the requirement that the RAC must hire a minimum of 1.0 full-time equivalent (FTE) Contractor Medical Director. The State shall require the RAC to hire no less than 0.1 FTE named and available medical director who is a Doctor of Medicine in good standing with the relevant State licensing authorities.</p> <p><input checked="" type="checkbox"/> The State/Medicaid agency has contracts of the type(s) listed in section 1902(a)(42)(B)(ii)(I) of the Act. All contracts meet the requirements of the statute. RACs are consistent with the statute.</p> <p>*On December 12, 2018 CMS approved State Plan Amendment SC 18-0009, granting a Recovery Audit Contractor (RAC) exemption request for the period from July 1, 2018, through June 30, 2020. In June 2020, SCDHHS posted a request for proposal for a RAC. We obtained two proposals and through evaluation, selected and engaged HMS to serve as SCDHHS' RAC.</p> <p>Place a check mark to provide assurance of the following:</p> <p><input checked="" type="checkbox"/> The State will make payments to the RAC(s) only from amounts recovered.</p> <p><input checked="" type="checkbox"/> The State will make payments to the RAC(s) on a contingent basis for collecting overpayments.</p> <p>The following payment methodology shall be used to determine State payments to Medicaid RACs for identification and recovery of overpayments (e.g., the percentage of the contingency fee):</p> <p><input checked="" type="checkbox"/> The State attests that the contingency fee rate paid to the Medicaid RAC will not exceed the highest rate paid to Medicare RACs, as published in the Federal Register.</p>
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Revision:

## STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: South Carolina

<p>Section 1902 (a)(42)(B)(ii)(II)(bb) of the Act</p> <p>Section 1902 (a)(42)(B)(ii)(III) of the Act</p> <p>Section 1902 (a)(42)(B)(ii)(IV)(aa) of the Act</p> <p>Section 1902(a)(42)(B)(ii)(IV)( bb) of the Act</p> <p>Section 1902 (a)(42)(B)(ii)(IV)(cc) Of the Act</p>	<p><u>    </u> The State attests that the contingency fee rate paid to the Medicaid RAC will exceed the highest rate paid to Medicare RACs, as published in the Federal Register. The State will only submit for FFP up to the amount equivalent to that published rate.</p> <p><u>    </u> The contingency fee rate paid to the Medicaid RAC that will exceed the highest rate paid to Medicare RACs, as published in the Federal Register. The State will submit a justification for that rate and will submit for FFP for the full amount of the contingency fee.</p> <p><u>  X  </u> The following payment methodology shall be used to determine State payments to Medicaid RACs for the identification of underpayments (e.g., amount of flat fee, the percentage of the contingency fee): <b>A contingency fee payment of 14% for all recovered overpayments and a contingency fee of 5% for all underpayments identified.</b></p> <p><u>  X  </u> The State has an adequate appeal process in place for entities to appeal any adverse determination made by the Medicaid RAC(s).</p> <p><u>  X  </u> The State assures that the amounts expended by the State to carry out the program will be amounts expended as necessary for the proper and efficient administration of the State plan or a waiver of the plan.</p> <p><u>  X  </u> The State assures that the recovered amounts will be subject to a State's quarterly expenditure estimates and funding of the State's share.</p> <p><u>  X  </u> Efforts of the Medicaid RAC(s) will be coordinated with other contractors or entities performing audits of entities receiving payments under the State plan or waiver in the State, and/or State and Federal law enforcement entities and the CMS Medicaid Integrity Program.</p>
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TN No: SC 21-0005  
Supersedes  
TN No: SC 18-0009

Approval Date: 06/03/21      Effective Date: 01/01/21

Revision: HCFA-AT-80-38 (BPP)  
May 22, 1980

State: \_\_\_\_\_ South Carolina \_\_\_\_\_

Citation  
42 CFR 431.16  
AT-79-29

4.6 Reports

The Medicaid agency will submit all reports in the form and with the content required by the Secretary, and will comply with any provisions that the Secretary finds necessary to verify and assure the correctness of the reports. All requirements of 42 CFR 431.16 are met.

\_\_\_\_\_  
TN No. 77-9  
Supersedes  
TN No. \_\_\_\_\_

Approval Date 2/15/79

Effective Date 1/01/78



Revision: HCFA-AT-80-38 (BPP)  
May 27, 1980

State: \_\_\_\_\_ South Carolina \_\_\_\_\_

Citation  
42 CFR 431.17  
AT-79-29

4.7 Maintenance of Records

The Medicaid agency maintains or supervises the maintenance of records necessary for the proper and efficient operation of the plan, including records regarding applications, determination of eligibility, the provision of medical assistance, and administrative costs, and statistical, fiscal and other records necessary for reporting and accountability, and retains these records in accordance with Federal requirements. All requirements of 42 CFR 431.17 are met.

TN No. 77-9  
Supersedes  
TN No. \_\_\_\_\_

Approval Date 2/15/79

Effective Date 1/01/78

Revision: HCFA-AT-80-38 (BPP)  
May 22, 1980

State: \_\_\_\_\_ South Carolina \_\_\_\_\_

Citation  
42 CFR 431.18 (b)  
AT-79-29

4.8 Availability of Agency Program Manuals

Program manuals and other policy issuances that affect the public, including the Medicaid agency's rules and regulations governing eligibility, need and amount of assistance, recipient rights and responsibilities, and services offered by the agency are maintained in the State office and in each local and district office for examination, upon request, by individuals for review, study, or reproduction. All requirements of 42 CFR 431.18 are met.

TN No. 75-4  
Supersedes \_\_\_\_\_  
TN No. \_\_\_\_\_

Approval Date 5/01/75

Effective Date 2/01/75

Revision: HCFA-AT-80-38 (BPP)  
May 22, 1980

State: \_\_\_\_\_ South Carolina \_\_\_\_\_

Citation  
42 CFR 433.37  
AT-78-90

4.9 Reporting Provider Payments to Internal Revenue Service

There are procedures implemented in accordance with 42 CFR 433.37 for identification of providers of services by social security number or by employer identification number and for reporting the information required by the Internal Revenue Code (26 U.S.C. 6041) with respect to payment for services under the plan.

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TN No. 75-4  
Supersedes \_\_\_\_\_  
TN No. \_\_\_\_\_

Approval Date 5/1/75

Effective Date 2/01/75

Revision: HCFA-PM-99-3  
June 1999

State: South Carolina

Citation 4.10 Free Choice of Providers

- 42 CFR 431.51 (a) Except as provided in paragraph(b), the Medicaid  
AT 78-90 agency assures that an individual eligible under  
46 FR 48524 the plan may obtain Medicaid Services from any  
48 FR 23212 institution, agency, pharmacy, person or  
1902(a) (23) organization that is qualified to perform the  
P.L. 100-93 services, including of the Act an organization  
(section 9(f)) that provides these services or arranges for  
P.L. 100-203 their availability on a prepayment basis.
- (Section 4113) (b) Paragraph (a) does not apply to services  
furnished to an individual.
- (1) Under an exception allowed under 42 CFR  
431.54, subject to the limitations in  
paragraph (c), or
- (2) Under a waiver approved under 42 CFR  
431.55, subject to the limitations in  
paragraph (c), or
- (3) By an individual or entity excluded from  
participation in accordance with section  
1902(p) of the Act,
- Section 1902(a) (23) (4) By individuals or entities who have been  
of the Social Security Act convicted of a felony under Federal or  
P.L. 105-33 State law and for which the State  
determines that the offense is  
inconsistent with the best interests of the  
individual eligible to obtain Medicaid  
services, or
- Section 1932(a) (1) (5) Under an exception allowed under 42 CFR  
Section 1905 (t) 438.50 or 42 CFR 440.168, subject to the  
limitations in paragraph (c).
- (c) Enrollment of an individual eligible for medical  
assistance in a primary care case management  
system described in section 1905(t), 1915(a),  
1915(b) (1), or 1932(a); or managed care  
organization, prepaid inpatient health plan, a  
prepaid ambulatory health plan, or a similar  
entity shall not restrict the choice of the  
qualified person from whom the individual may  
receive emergency services or services under  
section 1905(a) (4) (c).

TN No. MA 03-011  
Supersedes  
TN No. MA 92-007

Approval Date 11/06/03

Effective Date 8/13/03

Revision: HCFA-AT-80-38 (BPP)  
May 22, 1980

State: South Carolina

Citation  
42 CFR 431.610

4.11 Relations with Standard-Setting and Survey Agencies

AT-78-90  
AT-80-34

- (a) The State agency utilized by the Secretary to determine qualifications of institutions and suppliers of services to participate in Medicare is responsible for establishing and maintaining health standards for private or public institutions (exclusive of Christian Science sanatoria) that provides services to Medicaid recipients. This agency is THE DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL.
- (b) The State authority(ies) responsible for establishing and maintaining standards, other than those relating to health, for public or private institutions that provide services to Medicaid recipients is (are): THE DEPARTMENT OF SOCIAL SERVICES UNDER CONTRACT WITH THE DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL.
- (c) ATTACHMENT 4.11-A describes the standards specified in paragraphs (a) and (b) above, that are kept on file and made available to the Health Care Financing Administration on request.

TN No. 74-5  
Supersedes  
TN No. \_\_\_\_\_

Approval Date 6/13/74

Effective Date 4/15/74

Revision: HCFA-AT-80-38 (BPP)  
May 22, 1980

State: \_\_\_\_\_ South Carolina \_\_\_\_\_

Citation  
42 CFR 431.610  
AT-78-90  
AT-89-34

4.11(d)

The DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL (agency) which is the State agency responsible for Licensing health institutions, determines if institutions and agencies meet the requirements for participation in the Medicaid program. The requirements in 42 CFR 431.610(e), (f) and (g) are met.

\_\_\_\_\_  
TN No. 74-5  
Supersedes \_\_\_\_\_  
TN No. \_\_\_\_\_

Approval Date 6/13/74

Effective Date 04/15/74

Revision: HCFA-AT-80-38 (BPP)  
May 22, 1980

State: South Carolina

Citation  
42 CFR 431.105(b)  
AT-78-90

4.12 Consultation to Medical Facilities

- (a) Consultative services are provided by health and other appropriate State agencies to hospitals, nursing facilities, home health agencies, clinics and laboratories in accordance with 42 CFR 431.105(b).
- (b) Similar services are provided to other types of facilities providing medical care to individuals receiving services under the programs specified in 42 CFR 431.105(b).

Yes, as listed below:

Not applicable. Similar services are not provided to other types of medical facilities.

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TN No. MA 82-5  
Supersedes  
TN No. 73-11

Approval Date 05/19/82

Effective Date 1/01/82

Revision: HCFA-PM-91-4 (BPD)  
August 1991

OMB No.: 0938-

State/Territory: South Carolina

Citation 4.13 Required Provider Agreement

With respect to agreements between the Medicaid agency and each provider furnishing services under the plan:

- 42 CFR 431.107 (a) For all providers the requirements of 42 CFR 431.107 and 42 CFR Part 442, Subparts A and B (if applicable) are met.
- 42 CFR Part 483 1919 of the Act (b) For providers of NF services, the requirements of 42 CFR part 483, Subpart B, and section 1919 of the Act are also met.
- 42 CFR Part 483, Subpart D (c) For providers of ICR/MR services, the requirements of participation in 42 CFR Part 483, Subpart D are also met.
- 1920 of the Act (d) For each provider that is eligible under the plan to furnish ambulatory prenatal care to pregnant women during a presumptive eligibility period, all the requirements of section 1920 (b) (2) and (c) are met.
- Not applicable. Ambulatory prenatal care is not provided to pregnant women during a presumptive eligibility period.

TN No. MA 92-07  
Supersedes  
TN No. MA 87-16

Approval Date 6/04/92

Effective Date 01/01/92

HCFA ID: 7982E



Revision: HCFA-PM-91-9  
October 1991

(MB)

OMB No.:

State/Territory: South Carolina

Citation

1902 (a) (58)

1902 (w)

4.13 (e)

For each provider receiving funds under the plan, all the requirements for advance directives of section 1902(w) are met.

(1) Hospitals, nursing facilities, providers of home health care or personal care services, hospice programs, managed care organizations, prepaid inpatient health plans, prepaid ambulatory health plans (unless the PAHP excludes providers in 42 CFR 489.102), and health insuring organizations are required to do the following:

- (a) Maintain written policies and procedures with respect to all adult individuals receiving medical care by or through the provider or organization about their rights under State law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives.
- (b) Provide written information to all adult individuals on their policies concerning implementation of such rights;
- (c) Document in the individual's medical records whether or not the individual has executed an advance directive;
- (d) Not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive;
- (e) Ensure compliance with requirements of State law (whether

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TN No. MA 03-011

Supersedes

TN No. MA 91-19Approval Date 11/06/03Effective Date 08/13/03

Revision: HCFA-PM-91-4  
October 1991

(BPD)

OMB No.:

State/Territory: South Carolina

statutory or recognized by the courts) concerning advance directives; and

- (f) Provide (individually or with others) for education for staff and the community on issues concerning advance directives.
- (2) Providers will furnish the written information described in paragraph (1) (a) to all adult individuals at the time specified below:
- (a) Hospitals at the time an individual is admitted as an inpatient.
- (b) Nursing facilities when the individual is admitted as a resident.
- (c) Providers of home health care or personal care services before the individual comes under the care of the provider;
- (d) Hospice program at the time of initial receipt of hospice care by the individual from the program; and
- (e) Managed care organizations, health insuring organizations, prepaid inpatient health plans (as applicable) at the time of enrollment of the individual with the organization.
- (3) ATTACHMENT 4.34A describes law of the State (whether statutory or as recognized by the courts of the State) concerning advance directives.
- Not applicable. No State law or court decision exist regarding advance directives.

TN No. MA 03-011  
Supersedes  
TN No. MA 91-19

Approval Date 11/06/03Effective Date 08/13/03

Revision: HCFA-PM-91-10 (MB)  
December 1991

State/Territory: South Carolina

Citation 4.14 Utilization/Quality Control

- 42 CFR 431.60  
42 CFR 456.2  
50 FR 15312  
1902(a) (30) (C) and  
1902 (d) of the  
Act, P. 99-509  
(Section 9431)
- (a) A Statewide program of surveillance and utilization control has been implemented that safeguards against unnecessary or inappropriate use of Medicaid services available under this plan and against excess payment, and that assesses the quality of services. The requirements of 42 CFR Part 456 are met.
- Directly
- By undertaking medical and utilization review requirements through a contract with a Utilization and Quality Control Peer Review Organization (PRO) designated under 42 CFR Part 462. The contract with the PRO—
- (1) Meets the requirements of §434.6(a):
  - (2) Includes a monitoring and evaluation plan to ensure satisfactory performance;
  - (3) Identifies the services and providers subject to PRO review;
  - (4) Ensures that PRO review activities are not inconsistent with the PRO review of Medicare services; and
  - (5) Includes a description of the extent to which PRO determinations are considered conclusive for payment purposes.
- 1932(c) (2)  
and 1902(d) of the  
ACT, P.L. 99-509  
(section 9431)
- A qualified External Quality Review Organization performs an annual External Quality Review that meets the requirements of 42 CFR 438 Subpart E each managed care organization, prepaid inpatient health plan, and health insuring organizations under contract, except where exempted by the regulation.

TN No. MA 03-011  
Supersedes  
TN No. MA 96-005

Approval Date 11/06/03

Effective Date 08/13/03

Revision: HCFA-PM-85-3 (BERC)  
MAY 1985

State: South Carolina

OMB NO. 0938-0193

Citation  
42 CFR 456.2  
50 FR 15312

4.14 (b) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart C, for control of the utilization of inpatient hospital services.

- Utilization and medical review are performed by a Utilization and Quality Control Peer Review Organization designated under 42 CFR Part 462 that has a contract with the agency to perform those reviews.
- Utilization review is performed in accordance with 42 CFR Part 456, Subpart H, that specifies the conditions of a waiver of the requirements of Subpart C for:
- All hospitals (other than mental hospitals).
- Those specified in the waiver.
- No waivers have been granted.

TN No. MA 85-14  
Supersedes  
TN No. 81-16

Approval Date 09/24/85

Effective Date 07/01/85

HCFA ID: 0048P/0002P

Revision: HCFA-PM-85-3 (BERC)  
MAY 1985

State: South Carolina

OMB NO. 0938-0193

Citation  
42 CFR 456.2  
50 FR 15312

4.14 (c) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart D, for control of utilization of inpatient services in mental hospitals.

- Utilization and medical review are performed by a Utilization and Quality Control Peer Review Organization designated under 42 CFR Part 462 that has a contract with the agency to perform those reviews.
- Utilization review is performed in accordance with 42 CFR Part 456, Subpart H, that specifies the conditions of a waiver of the requirement of Subpart D for:
- All mental hospitals.
- Those specified in the waiver.
- No waivers have been granted. For Medicaid sponsorship prior approval for admission (or upon request for payment) and/or level of care is required.

TN No. MA 85-14  
Supersedes  
TN No. 81-16

Approval Date 09/24/85

Effective Date 7/01/85

HCFA ID: 0048P/0002P

Revision: HCFA-PM-85-3 (BERC)  
MAY 1985

State: South Carolina

OMB NO. 0938-0193

Citation  
42 CFR 456.2  
50 FR 15312

4.14 (d) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart E, for the control of utilization of skilled nursing facility services.

- Utilization and medical review are performed by a Utilization and Quality Control Peer Review Organization designated under 42 CFR Part 462 that has a contract with the agency to perform those reviews.
- Utilization review is performed in accordance with 42 CFR Part 456, Subpart H, that specifies the conditions of a waiver of the requirements of Subpart E for:
- All skilled nursing facilities.
- Those specified in the waiver.
- No waivers have been granted. For Medicaid sponsorship prior approval for admission (or upon request for payment) and/or level of care is required.

TN No. MA 85-14  
Supersedes  
TN No. 81-16

Approval Date 09/24/85

Effective Date 07/01/85

Revision: HCFA-PM-85-3 (BERC)  
MAY 1985

State: South Carolina

OMB. No. 0938-0193

Citation  
42 CFR 456.2  
50 FR 15312

- 4.14  (e) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart F, for control of the utilization of intermediate care facility services. Utilization review in facilities is provided through:
- Facility-based review.
  - Direct review by personnel of the medical assistance unit of the State agency.
  - Personnel under contract to the medical assistance unit of the State agency.
  - Utilization and Quality Control Peer Review Organizations.
  - Another method as described in ATTACHMENT 4.14-A.
  - Two or more of the above methods. ATTACHMENT 4.14-B describes the circumstances under which each method is used.
- Not applicable. Intermediate care facility services are not provided under this plan.

TN No. MA 85-14  
Supersedes  
TN No. 81-16

Approval Date 09/24/85

Effective Date 07/01/85

HCFA ID: 0048P/0002P

Revision: HCFA-PM-91-10 (MB)  
December 1991

State/Territory: South Carolina

Citation 4.14 Utilization/Quality Control (Continued)

42 CFR 438.356(e) For each contract, the State must follow an open, competitive procurement process that is in accordance with State law and regulations and consistent with 45 CFR Part 74 as it applies to State procurement of Medicaid services.

42 CFR 438.354  
42 CFR 438.356(b) and (d) The State must ensure that an External Quality Review Organization and its subcontractors performing the External Quality Review or External Quality Review-related activities meets the competence and independence requirements.

Not applicable.

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TN No. MA 03-011  
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TN No. MA-96-005

Approval Date 11/06/03

Effective Date 08/13/03



Revision: HCFA-PM-92-2 (HSQB)  
MARCH 1992

State/Territory: South Carolina

Citation 4.15 Inspection of Care in Intermediate Care Facilities for the Mentally Retarded, Facilities Providing Inpatient Psychiatric Services for Individuals Under 21, and Mental Hospitals

42 CFR Part  
456 Subpart  
I, and  
1902(a) (31)  
and 1903(q)  
of the Act

\_\_\_\_\_ The State has contracted with a Peer Review Review Organization (PRO) to perform inspection of care for:

\_\_\_\_\_ ICFs/MR;

\_\_\_\_\_ Inpatient psychiatric facilities for recipients under age 21; and

\_\_\_\_\_ Mental Hospitals.

42 CFR Part  
456 Subpart  
A and  
1902(a) (30)  
of the Act

X All applicable requirements of 42 CFR Part 456, Subpart I, are met with respect to periodic inspections of care and services.

\_\_\_\_\_ Not applicable with respect to intermediate care facilities for the mentally retarded services; such services are not provided under this plan.

\_\_\_\_\_ Not applicable with respect to services for individuals age 65 or over in institutions for mental disease; such services are not provided under this plan.

\_\_\_\_\_ Not applicable with respect to inpatient psychiatric services for individuals under age 21; such services are not provided under this plan.

TN No. MA 92-10  
Supersedes  
TN No. MA-81-16

Approval Date 10/20/92

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HCFA ID: \_\_\_\_\_

Revision: HCFA-AT-80-38 (BPP)  
May 22, 1980

State: \_\_\_\_\_ South Carolina \_\_\_\_\_

Citation  
42 CFR 431.615(c)  
AT-78-90

4.16 Relations with State Health and Vocational  
Rehabilitation Agencies and Title V Grantees

The Medicaid agency has cooperative arrangements with State health and vocational rehabilitation agencies and with title V grantees, that meet the requirements of 42 CFR 431.615.

ATTACHMENT 4.16-A describes the cooperative arrangements with the health and vocational rehabilitation agencies.

TN No. 76-35  
Supersedes  
TN No. \_\_\_\_\_

Approval Date 01/10/78

Effective Date 01/01/77

Revision: HCFA-PM-95-3 (MB)  
May 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: South Carolina

Citation (s)

42 CFR 433.36 (c)  
1902(a) (18) and  
1917(a) and (b) of  
The Act

4.17 Liens and Adjustments or Recoveries

(a) Liens

\_\_\_\_\_ The State imposes liens against an individual's real property on account of medical assistance paid or to be paid.

The State complies with the requirements of section 1917 (a) of the Act and regulations at 42 CFR 433.36 (c)-(g) with respect to any lien imposed against the property of any individual prior to his or her death on account of medical assistance paid or to be paid on his or her behalf.

\_\_\_\_\_ The State imposes liens on real property on account of benefits incorrectly paid.

\_\_\_\_\_ The State imposes TEFRA liens 1917 (a) (1) (B) on real property of an individual who is an inpatient of a nursing facility, ICF/MR, or other medical institution, where the individual is required to contribute toward the cost of institutional care all but a minimal amount of income required for personal needs.

The procedures by the State for determining that an institutionalized individual cannot reasonably be expected to be discharged are specified in Attachment 4.17-A. (NOTE: If the State indicates in its State Plan that it is imposing TEFRA liens, then the State is required to determine whether an institutionalized individual is permanently institutionalized and afford these individuals notice, hearing procedures, and due process requirements.)

\_\_\_\_\_ The State imposes liens on both real and personal property of an individual after the individual's death.

TN No.: 06-009  
Supersedes  
TN No.: 83-4

Approval Date: 07/20/07

Effective Date: 07/01/06

## STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: South Carolina

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**(b) Adjustments or Recoveries**

The State complies with the requirements of section 1917(b) of the Act and regulations at 42 CFR 433.36 (h)-(i).

Adjustments or recoveries for Medicaid claims correctly paid are as follows:

- (1) For permanently institutionalized individuals, adjustments or recoveries are made from the individual's estate or upon sale of the property subject to a lien imposed because of medical assistance paid on behalf of the individual for services provided in a nursing facility, ICF/MR, or other medical institution.

\_\_\_\_\_ Adjustments or recoveries are made for all other medical assistance paid on behalf of the individual.

- (2) The State determines "permanent institutional status" of individuals under the age of 55 other than those with respect to whom it imposes liens on real property under §1917 (a) (1) (B) (even if it does not impose those liens).

- (3) For any individual who received medical assistance at age 55 or older, adjustments or recoveries of payments are made from the individual's estate for nursing facility services, home and community-based services, and related hospital and prescription drug services.

\_\_\_\_\_ In addition to adjustment or recovery of payments for services listed above, payments are adjusted or recovered for other services under the State Plan as listed below:

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TN No.: 06-009  
Supersedes  
TN No.: 83-4

Approval Date: 07/20/07

Effective Date: 07/01/06

Revision: HCFA-PM-95-3 (MB)  
May 1995

## STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: South Carolina

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- (4)  The State disregards assets or resources for individuals who receive or are entitled to receive benefits under a long term care insurance policy as provided for in Attachment 2.6-A, Supplement 8b.
- The State adjusts or recovers from the individual's estate on account of all medical assistance paid for nursing facility and other long-term care services provided on behalf of the individual. (States other than California, Connecticut, Indiana, Iowa, and New York which provide long term care insurance policy-based asset or resource disregard must select this entry. These five States may either check this entry or one of the following entries.)
- The State does not adjust or recover from the individual's estate on account of any medical assistance paid for nursing facility or other long term care services provided on behalf of the individual.
- The State adjusts or recovers from the assets or resources on account of medical assistance paid for nursing facility or other long term care services provided on behalf of the individual to the extent described below:

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TN No.: 06-009

Supersedes

Approval Date: 07/20/07

Effective Date: 07/01/06

TN No.: New

## STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: South Carolina(c) Adjustments or Recoveries: Limitations

The State complies with the requirements of section 1917 (b) (2) of the Act and regulations at 42 CFR §433.36 (h)-(i).

- (1) Adjustment or recovery of medical assistance correctly paid will be made only after the death of the individual's surviving spouse, and only when the individual has no surviving child who is either under age 21, blind, or disabled.
- (2) With respect to liens on the home of any individual who the State determines is permanently institutionalized and who must as a condition of receiving services in the institution apply their income to the cost of care, the State will not seek adjustment or recovery of medical assistance correctly paid on behalf of the individual until such time as none of the following individuals are residing in the individual's home:
  - (a) a sibling of the individual (who was residing in the individual's home for at least one year immediately before the date that the individual was institutionalized), or
  - (b) a child of the individual (who was residing in the individual's home for at least two years immediately before the date that the individual was institutionalized) who establishes to the satisfaction of the State that the care the child provided permitted the individual to reside at home rather than become institutionalized.
- (3) No money payments under another program are reduced as a means of adjusting or recovering Medicaid claims incorrectly paid.

## STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: South Carolina(d) ATTACHMENT 4.17-A

- (1) Specifies the procedures for determining that an institutionalized individual cannot reasonably be expected to be discharged from the medical institution and return home. The description of the procedure meets the requirements of 42 CFR 433.36(d).
- (2) Specifies the criteria by which a son or a daughter can establish that he or she has been providing care, as specified under 42 CFR 433.36 (f).
- (3) Defines the following terms:
  - Estate (at a minimum, estate as defined under State probate law). Except for the grandfathered States listed in section 4.17 (b) (3), if the State provides a disregard for assets or resources for any individual who received or is entitled to receive benefits under a long term care insurance policy, the definition of estate must include all real, personal property, and assets of an individual (including any property or assets in which the individual had any legal title or interest at the time of death to the extent of the interest and also including the assets conveyed through devices such as joint tenancy, life estate, living trust, or other arrangement),
  - individual's home,
  - equity interest in the home,
  - residing in the home for at least 1 or 2 years,
  - on a continuous basis,
  - discharge from the medical institution and return home, and
  - lawfully residing.

Revision: HCFA-PM-95-3 (MB)  
May 1995

## STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: South Carolina

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- (4) Describes the standards and procedures for waiving estate recovery when it would cause undue hardship.
- (5) Defines when adjustment or recovery is not cost-effective. Defines cost-effective and includes methodology or thresholds used to determine cost-effectiveness.
- (6) Describes collection procedures. Includes advance notice requirements, specifies the method for applying for a waiver, hearing and appeals procedures, and the time frames involved.

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TN No.: 06-009

Supersedes

TN No.: New

Approval Date: 07/20/07

Effective Date: 07/01/06



Revision: HCFA-AT-91-4 (BPD)  
AUGUST 1991

OMB No.: 0938-

State/Territory: South Carolina

Citation  
42 CFR 447.51  
through 447.58

4.18 Recipient Cost Sharing and Similar Charges

1916(a) and (b)  
of the Act

- (a) Unless a waiver under 42 CFR 431.55(g) applies, deductibles, coinsurance rates, and copayments do not exceed the maximum allowable charges under 42 CFR 447.54.
- (b) Except as specified in items 4.18(b)(4), (5), and (6) below, with respect to individuals covered as categorically needy or as qualified Medicare beneficiaries (as defined in section 1905(p)(1) of the Act) under the plan:
- (1) No enrollment fee, premium, or similar charge is imposed under the plan.
  - (2) No deductible, coinsurance, copayment, or similar charge is imposed under the plan for the following:
    - (i) Services to individuals under age 18, or under--
      - [ x ] Age 19
      - [ ] Age 20
      - [ ] Age 21

Reasonable categories of individuals who are age 18 or older, but under age 21, to whom charges apply are listed below, if applicable.
    - (ii) Services to pregnant women related to the pregnancy or any other medical condition that may complicate the pregnancy.

TN MA 03-013  
Supersedes  
TN MA 03-011

Effective Date 01/01/04  
Approval Date 11/26/03

Revision: HCFA-PM-91-4 (BPD)  
AUGUST 1991

OMB No.: 0938-

State/Territory: South Carolina

Citation 4.18(b)(2) (Continued)

42 CFR 447.51  
through  
447.58

(iii) All services furnished to pregnant women.  
women.

[x] Not applicable. Charges apply for  
services to pregnant women unrelated to  
the pregnancy.

(iv) Services furnished to any individual who  
is an inpatient in a hospital, long-term  
care facility, or other medical  
institution, if the individual is  
required, as a condition of receiving  
services in the institution to spend for  
medical care costs all but a minimal  
amount of his or her income required for  
personal needs.

(v) Emergency services if the services meet  
the requirements in 42 CFR 447.53(b)(4).

(vi) Family planning services and supplies  
furnished to individuals of childbearing  
age.

(vii) Services furnished by a managed care  
organization, health insuring  
organization, prepaid inpatient health  
plan, or prepaid ambulatory health plan  
in which the individual is enrolled,  
unless they meet the requirements of 42  
CFR 447.60.

42 CFR 438.108  
42 CFR 447.60

[ x ] Managed care enrollees may be  
charged deductibles, coinsurance  
rates, and copayments in an amount  
equal to the State Plan service  
cost-sharing.

[ ] Managed care enrollees are not  
charged deductibles, coinsurance  
rates, and copayments.

1916 of the Act,  
P.L. 99-272,  
(Section 9505)

(viii) Services furnished to an individual  
receiving hospice care, as defined  
in section 1905(o) of the Act.

TN MA 03-016

Effective Date 01/01/04

Supersedes

Approval Date 02/04/04

TN MA 03-011

Revision: HCFA-PM-91-4 (BPD)  
AUGUST 1991

OMB No.: 0938-

State/Territory: South Carolina

Citation 4.18(b)(2) (Continued)

1916 and 1916 A of the Act  
Section 5006 (a)

- (ix) Services to an Indian who is currently or has previously used services provided by the IHS or an Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U), or through a referral under contract health services in any State.
- (x) Medical equipment/supplies and orthodontic services provided by South Carolina Department of Health and Environmental Control (DHEC).
- (xi) End Stage Renal Disease (ESRD) services and services provided in an infusion center.
- (xii) Members of the Health Opportunity Account Program (HOA).

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TN SC 11-001 Approval Date 04/01/11 Effective Date: 04/01/11  
 Supersedes  
 TN New Page

Revision: HCFA-AT-91-4 (BPD)  
AUGUST 1991

OMB No.: 0938-

Citation  
42 CFR 447.51  
through 447.58

4.18 (b) (continued)

(3) Unless a waiver under 42 CFR 431.55(g) applies, nominal deductibles, coinsurance, copayment or similar charges are imposed for services that are not excluded from such charges under item (b) (2) above.

Not applicable. No such charges are imposed.

(i) For any service, no more than one type of charge is imposed.

(ii) Charges apply to services furnished to the following age groups:

18 or older

19 or older

20 or older

21 or older

Charges apply to services furnished to the following reasonable categories of individuals listed below who are 18 years of age or older but under age 21.

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TN MA 03-013  
Supersedes  
TN MA 92-007

Effective Date 01/01/04  
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August 1991

OMB No.: 0938-

State/Territory: South Carolina

Citation  
42 CFR 447.51  
through 447.58

4.18(b) (3) (Continued)

(iii) For the categorically needy and qualified Medicare beneficiaries, ATTACHMENT 4.18-A specifies the:

- (A) Service(s) for which a charge(s) is applied;
  - (B) Nature of the charge imposed on each service;
  - (C) Amount(s) of and basis for determining the charge(s);
  - (D) Method used to collect the charge(s);
  - (E) Basis for determining whether an individual is unable to pay the charge and the means by which such an individual is identified to providers;
  - (F) Procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b); and
  - (G) Cumulative maximum that applies to all deductibles, coinsurance or copayment charges imposed on a specified time period.
- Not applicable. There is no maximum.

TN No. MA 92-07  
Supersedes  
TN No. MA 90-11

Approval Date 06/04/92

Effective Date 01/01/92

HFCA ID: 7982E

Revision: HCFA-PM-91-4 (BPD)  
August 1991

OMB No.: 0938-

State/Territory: South Carolina

Citation

- |  |                                      |  |
|--|--------------------------------------|--|
| 1916(c) of<br>the Act                      | 4.18(b) (4) <input type="checkbox"/> | A monthly premium is imposed on pregnant women and infants who are covered under section 1902(a) (10) (A) (ii) (IX) of the Act and whose income equals or exceeds 150 percent of the Federal poverty level applicable to a family of the size involved. The requirements of section 1916(c) of the Act are met. <u>ATTACHMENT 4.18-D</u> specifies the method the State uses for determining the premium and the criteria for determining what constitutes undue hardship for waiving payment of premiums by recipients. |
| 1902 (a) (52)<br>and 1925(b)<br>of the Act | 4.18(b) (5) <input type="checkbox"/> | For families receiving extended benefits during a second 6-month period under section 1925 of the Act, a monthly premium is imposed in accordance with sections 1925(b) (4) and (5) of the Act.  |
| 1916(d) of<br>the Act                      | 4.18(b) (6) <input type="checkbox"/> | A monthly premium, set on a sliding scale, imposed on qualified disabled and working individuals who are covered under section 1902(a) (10) (E) (ii) of the Act and whose income exceeds 150 percent (but does not exceed 200 percent) of the Federal poverty level applicable to a family of the size involved. The requirements of section 1916(d) of the Act are met. <u>ATTACHMENT 4.18-E</u> specifies the method and standards the State uses for determining the premium.   |

TN No. MA 92-07  
Supersedes  
TN No. MA 90-02

Approval Date 06/04/92

Effective Date 01/01/92

HCFA ID: 7982E

Revision: HCFA-PM-91-4 (BPD)  
August 1991

OMB No.: 0938-

State/Territory: South Carolina

Citation 4.18(c)  Individuals are covered as medically needy under the plan.

42 CFR 447.51  
through 447.58

- (1)  An enrollment fee, premium or similar charge is imposed. ATTACHMENT 4.18-B specifies the amount of and liability period for such charges subject to the maximum allowable charges in 42 CFR 447.52 (b) and defines the State's policy regarding the effect on recipients of non-payment of the enrollment fee, premium, or similar charge.

447.51 through  
447.58

- (2) No deductible, coinsurance, copayment, or similar charge is imposed under the plan for the following:

- (i) Services to individuals under age 18, or Under--

Age 19

Age 20

Age 21

Reasonable categories of individuals who are age 18 , but under age 21, to whom charges apply are listed below, if applicable:

TN No. MA 92-023

Supersedes

TN No. MA 92-07

Approval Date 02/19/93

Effective Date 10/01/92

HCFA ID: 7982E

Revision: HCFA-PM-91-4 (BPD)  
August 1991

OMB No.: 0938-

State/Territory: South Carolina

Citation 4.18(c) (2) (Continued)

42 CFR 447.51  
through  
447.58

(ii) Services to pregnant women related to the pregnancy or any other medical condition that may complicate the pregnancy.

(iii) All services furnished to pregnant women.

Not applicable. Charges apply for services to pregnant women unrelated to the pregnancy.

(iv) Services furnished to any individual who is an inpatient in a hospital, long-term care facility, or other medical institution, if the individual is required, as a condition of receiving services in the institution, to spend for medical care costs all but a minimal amount of his income required for personal needs.

(v) Emergency services if the services meet the requirements in 42 CFR 447.53(b) (4).

(vi) Family planning services and supplies furnished to individuals of childbearing age.

1916 of the Act  
P.L. 99-272  
(Section 9505)

(vii) Services furnished to an individual receiving hospice care, as defined in section 1905(o) of the Act.

447.51 through  
447.58

(viii) Services provided by a health maintenance organization (HMO) to enrolled individuals.

Not applicable. No such charges are imposed.

TN No. 96-005  
Supersedes  
TN No. MA 92-07

Approval Date 07/02/96

Effective Date 6/01/96

HCFA ID: 7982E



Revision: HCFA-AT-91-4 (BPD)  
August 1991

OMB No.: 0938-

State/Territory: South Carolina

Citation 4.18(c) (3) Unless a waiver under 42 CFR 431.55(g) applies, nominal deductibles, coinsurance, copayment or similar charges are imposed on services that are not excluded from such charges under item (b) (2) above.

Not applicable. No such charges are imposed.

(i) For any service, no more than one type of charge is imposed.

(ii) Charges apply to services furnished to the following age groups:

18 or older

19 or older

20 or older

21 or older

Reasonable categories of individuals who are 18 years of age, but under 21, to whom charges apply are listed below, if applicable.

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TN No. MA 03-013

Supersedes

TN No. MA 92-007

Approval Date 11/26/03

Effective Date 01/01/04

Revision: HCFA-PM-91-4 (BPD)  
AUGUST 1991

OMB No.: 0938

State/Territory: South Carolina

Citation 41.8(c) (3) (Continued)

- 447.51 through 4447.58 (iii) For the medically needy, and other optional groups, ATTACHMENT 4.18-C specifies the:
- (A) Service(s) for which charge(s) is applied;
  - (B) Nature of the charge imposed on each service;
  - (C) Amount(s) of and basis for determining the charge(s);
  - (D) Method used to collect the charges(s);
  - (E) Basis for determining whether an individual is unable to pay the charge(s) and the means by which such an individual is identified to providers;
  - (F) Procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b); and
  - (G) Cumulative maximum that applies to all deductible, coinsurance, or copayment charges imposed on family during a specified time period.
- Not applicable. There is no maximum.

TN No. MA 92-023

Supersedes

TN No. MA 92-07

Approval Date 02/19/93

Effective Date 10/01/92

HCFA ID: 7982E

Revision: HCFA-PM-91-4 (BPD)  
AUGUST 1991

OMB No.: 0938-

State/Territory: South Carolina

Citation 4.19 Payment for Services

42 CFR 447.252  
1902(a) (13)  
and 1923 of  
the Act

- (a) The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart C, and sections 1902(a) (13) and 1923 of the Act with respect to payment for inpatient hospital services.

ATTACHMENT 4.19-A describes the methods and standards used to determine rates for payment for inpatient hospital services.

- Inappropriate level of care days are covered and are paid under the State plan at lower rates than other inpatient hospital services, reflecting the level of care actually received, in a manner consistent with section 1861(v) (1) (G) of the Act.
- Inappropriate level of care days are not covered.

TN No. MA 94-021

Supersedes

TN No. MA 92-07

Approval Date 06/01/95

Effective Date 10/01/94

HCFA ID: 7982E

Revision: HCFA-PM-91-4 (BPD)  
August 1991

OMB No.: 0938-

State/Territory: South Carolina

Citation

42 CFR 447.201  
42 CFR 447.302  
52 FR 28648  
1902(a)(13)(E)  
1903(a)(1) and  
(n), 1920, and  
1926 of the Act

4.19(b)

In addition to the services specified in paragraphs 4.19(a), (d), (k), (l), and (m), the Medicaid agency meets the following requirements:

- (1) Section 1902(a)(13)(E) of the Act regarding payment for services furnished by Federally qualified health centers (FQHCs) under section 1905(a)(2)(C) of the Act. The agency meets the requirements of section 6303 of the State Medicaid Manual (HCFA-Pub. 45-6) regarding payment for FQHC services. ATTACHMENT 4.19-B describes the method of payment and how the agency determines the reasonable costs of the services (for example, cost-reports, cost or budget reviews, or sample surveys).
- (2) Sections 1902(a)(13)(E) and 1926 of the Act, and 42 CFR Part 447, Subpart D, with respect to payment for all other types of ambulatory services provided by rural health clinics under the plan.

ATTACHMENT 4.19-B describes the methods and standards used for the payment of each of these services except for inpatient hospital, nursing facility services, and services in intermediate care facilities for the mentally retarded that are described in other attachments.

TN No. MA 92-07

Supersedes

TN No. MA 90-15

Approval Date 06/04/92

Effective Date 01/01/92

HCFA ID: 7982E

Revision: HCFA-AT-80-38 (BPP)  
May 22, 1980

State: South Carolina

Citation  
42 CFR 447.40  
AT-78-90

4.19(c)

Payment is made to reserve a bed during a recipient's temporary absence from an inpatient facility.

Yes. The State's policy is described in ATTACHMENT 4.19-C.

No.

TN No. 77-9  
Supersedes  
TN No. \_\_\_\_\_

Approval Date 02/15/79

Effective Date 01/01/78

Revision: HCFA-PM-87-9 (BERC)  
August 1987

OMB No.: 0938-0193

State/Territory: South Carolina

Citation 4.19(d)

42 CFR 447.252

47 FR 47964

48 FR 56046

42 CFR 447.280

47 FR 31518

52 FR 28141

- (1) The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart C, with respect to payments for skilled nursing and intermediate care facility services.

ATTACHMENT 4.19-D describes the methods and standards used to determine rates for payment for skilled nursing and intermediate care facility services.

- (2) The Medicaid agency provides payment for routine skilled nursing facility services furnished by a swing-bed hospital.

At the average rate per patient day paid to SNFs for routine services furnished during the previous calendar year.

At a rate established by the State, which meets the requirements of 42 CFR Part 447, Subpart C, as applicable.

Not applicable. The agency does not provide payment for SMF services to a swing-bed hospital.

- (3) The Medicaid agency provides payment for routine intermediate care facility services furnished by a swing-bed hospital.

At the average rate per patient day paid to ICFs, other than ICFs for the mentally retarded, for routine services furnished during the previous calendar year.

At a rate established by the State, which meets the requirements of 42 CFR part 447, Subpart C, as applicable.

Not applicable. The agency does not provide payment for ICF services to a swing-bed hospital.

- (4) Section 4.19(d)(1) of this plan is not applicable with respect to intermediate care facility services; such services are not provided under this State Plan.

TN No. MA 88-03

Supersedes

TN No. MA 86-04

Approval Date 07/21/88

Effective Date 01/01/88

HCFA ID: 1010P/0012P

Revision: HCFA-AT-80-38 (BPP)  
May 22, 1980

State: South Carolina

Citation  
42 CFR 447.45(c)  
AT-79-50

4.19(e)

The Medicaid agency meets all requirements of 42 CFR 447.45 for timely payment of claims.

ATTACHMENT 4.19-E specifies, for each type of service, the definition of a claim for purposes of meeting these requirements.

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TN No. 79-10  
Supersedes \_\_\_\_\_  
TN No. \_\_\_\_\_

Approval Date 12/26/79

Effective Date 09/30/79

Revision: HCFA-PM-87-4 (BERC)  
MARCH 1987

OMB No.: 0938-0193

State/Territory: South Carolina

Citation  
42 CFR 447.15  
AT-78-90  
AT 80-34  
48 FR 5730

4.19(f)

The Medicaid agency limits participation to providers who meet the requirements of 42 CFR 447.15.

No provider participating under this plan may deny services to any individual eligible under the plan on account of the individual's inability to pay a cost sharing amount imposed by the plan in accordance with 42 CFR 431.55(g) and 447.53. This service guarantee does not apply to an individual who is able to pay, nor does an individual's inability to pay eliminate his or her liability for the cost sharing change.

TN No. MA 87-16  
Supersedes  
TN No. MA 83-06

Approval Date 10/13/87

Effective Date 07/01/87

HCFA ID: 1010P/0012P



Revision: HCFA-AT-80-38 (BPP)  
May 22, 1980

State: South Carolina

<u>Citation</u>	4.19(g)	The Medicaid agency assures appropriate audit of
42 CFR 447.201		records when payment is based on costs of
42 CFR 447.202		services or on a fee plus cost of materials.
AT-78-90		

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TN No. 79-6  
Supersedes \_\_\_\_\_  
TN No. \_\_\_\_\_

Approval Date 10/23/79

Effective Date 09-30-79

Revision: HCFA-AT-80-38 (BPP)  
May 22, 1980

State: South Carolina

<u>Citation</u>	4.19(h)	The Medicaid agency meets the requirements of
42 CFR 447.201		42 CFR 446.203 for documentation and availability
42 CFR 447.203		of payment rates.
AT-78-90		

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TN No. 79-6  
Supersedes \_\_\_\_\_  
TN No. \_\_\_\_\_

Approval Date 10/23/79

Effective Date 09/30/79

Revision: HCFA-AT-80-38 (BPP)  
May 22, 1980

State: South Carolina

Citation  
42 CFR 447.201  
42 CFR 447.204  
AT-78-90

4.19(i)

The Medicaid agency's payments are sufficient to enlist enough providers so that services under the plan are available to recipients at least to the extent that those services are available to the general population.

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TN No. 79-6  
Supersedes  
TN No. \_\_\_\_\_

Approval Date 10/23/79

Effective Date 09-30-79

Revision: HCFA-PM-91-4 (BPD)  
AUGUST 1991

OMB No.: 0938-

State: South Carolina

Citation

42 CFR 447.201 and 447.205	4.19 (j)	The Medicaid agency meets the requirements of 42 CFR 447.205 for public notice of any changes in Statewide method or standards for setting payment rates.
1903(v) of the Act	(k)	The Medicaid agency meets the requirements of section 1903(v) of the Act with respect to payment for medical assistance furnished to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law. Payment is made only for care and services that are necessary for the treatment of an emergency medical condition, as defined in section 1903(v) of the Act.

TN No. MA 92-07  
Supersedes  
TN No. MA 88-03

Approval Date 06/04/92

Effective Date 01/01/92

HCFA ID: 7982E

Revision: HCFA-AT-81-34 (BPP)

10-81

State: South Carolina

Citation  
42 CFR 447.342  
46 FR 42669

4.19(k)

Payments to Physicians for Clinical Laboratory Services

For services performed by an outside laboratory for a physician who bills for the service, payment does not exceed the amount that would be authorized under Medicare in accordance with 42 CFR 405.515(b), (c) and (d).

- Yes
- Not applicable. The Medicaid agency does not allow payment under the plan to physicians for outside laboratory services.

TN No. MA 81-14  
Supersedes \_\_\_\_\_  
TN No. \_\_\_\_\_

Approval Date 11/25/81

Effective Date 07-01-81

Revision: HCFA-AT-94-8 (MB)  
October 1994

State/Territory: South Carolina

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Citation

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- 4.19 (m) Medicaid Reimbursement for Administration of Vaccines Under the Pediatric Immunization Program
- 1928(c)(2)(i) (i) A provider may impose a charge for the administration of a qualified pediatric vaccine as stated in 1928(c)(2)(c)(ii) of the Act. Within this overall provision, Medicaid reimbursement to providers will be administered as follows:
- (ii) The State:
- X   sets a payment rate at the level of the Regional maximum established by the DHHS Secretary.
- is a Universal Purchase State and sets a Payment rate at the level of the regional maximum established in accordance with State law.
- sets a payment rate below the level of the Regional maximum established by the DHHS Secretary.
- is a Universal Purchase State and sets a Payment Rate below the level of the regional maximum established by the Universal Purchase State.
- The State pays the following rate for the administration of a vaccine:
- 1926 of (iii) Medicaid beneficiary access to immunization  
the act is assured through the following methodology:

Revision: HCFA-AT-80-38 (BPP)  
May 22, 1980

State: South Carolina

Citation  
42 CFR 447.25 (b)  
AT-78-90

4.20 Direct Payments to Certain Recipients for  
Physicians' or Dentists' Services

Direct payments are made to certain recipients as specified by, and in accordance with, the requirements of 42 CFR 447.25.

Yes, for physicians' services

dentists' services

ATTACHMENT 4.20-A specifies the conditions under which such payment are made.

Not applicable. No direct payments are made to recipients.

TN No. 79-6

Supersedes

TN No. \_\_\_\_\_

Approval Date 10/23/79

Effective Date 09-30-79

Revision: HCFA-AT-81-34 (BPP)

State: South Carolina

Citation 4.21 Prohibition Against Reassignment of  
Provider Claims

42 CFR 447.10(c)  
AT 78-90  
46 FR 42699

Payment for Medicaid services  
furnished by any provider under this  
plan is made only in accordance with  
the requirements of 42 CFR 447.10.

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TN No. MA 81-14  
Supersedes  
TN No. 78-5

Approval Date 11/25/81

Effective Date 07/01/81



Revision: HCFA-PM-90-2 (BPD)  
JANUARY 1990

OMB No.: 0938-0193

State/Territory: South Carolina

<u>Citation</u>	<u>4.22 Third Party Liability</u>
433.137(a) 50 FR 46652 55 FR 1423	(a) The Medicaid agency meets all requirements of 42 CFR 433.138 and 433.139
433.138(f) 52 FR 5967	(b) <u>ATTACHMENT 4.22-A--</u> (1) Specifies the frequency with which the data exchanges required in §433.138(d)(1), (d)(3) and (d)(4) and the diagnosis and trauma code edits required in §433.138(e) are conducted;
433.138(g)(1)(ii) and (2)(ii) 52 FR 5967	(2) Describes the methods the agency uses for meeting the follow-up requirements contained in §433.138(g)(1)(i) and (g)(2)(i);
433.138(g)(3)(i) and (iii) 52 FR 5967	(3) Describes the methods the agency uses for following up on information obtained through the State motor vehicle accident report file data exchange required under §433.138(d)(4)(ii) and specifies the time frames for incorporation into the eligibility case file and into its third party data base and third party recovery unit of all information obtained through the follow-up that identifies legally liable third party resources; and
433.138(g)(4)(i) through (iii) 52 FR 5967	(4) Describes the methods the agency uses for following up on paid claims identified under §433.138(e) (methods include a procedure for periodically identifying those trauma codes that yield the highest third party collections and giving priority to following up on those codes) and specifies the time frames for incorporation into the eligibility case file and into its third party data base and third party recovery unit of all information obtained through the follow-up that identifies legally liable third party resources.

TN No. MA 90-19

Supersedes

TN No. MA 88-03

Approval Date 04/16/91

Effective Date 07/01/90

HCFA ID: 1010P/0012P

Revision: HCFA-PM-90-2 (BPD)  
JANUARY 1990

OMB No.: 0938-0193

State/Territory: South Carolina

- Citation                        (c)    Providers are required to bill liable third parties when services covered under the plan are furnished to an individual on whose behalf child support enforcement is being carried out by the State IV-D agency.
- 433.139(b) (3)  
(ii) (A)  
55 FR 1423
- (d)    ATTACHMENT 4.22-B specifies the following:
- 433.139(b) (3) (ii) (C)                    (1)    The method used in determining a provider's compliance with the third party billing requirements at §433.139(b) (3) (ii) (C).
- 55 FR 1423
- 433.139(f) (2)                                (2)    The threshold amount or other guideline used in determining whether to seek recovery of reimbursement from a liable third party, or the process by which the agency determines that seeking recovery of reimbursement would not be cost effective.
- 50 FR 46652
- 433.139(f) (3)                                (3)    The dollar amount or time period the State uses to accumulate billings from a particular liable third party in making the decision to seek recovery of reimbursement.
- 50 FR 46652
- 433.139(b) (1)                                (4)    The requirement for states to apply cost avoidance procedures to claims for prenatal services, including labor, delivery, and postpartum care services.
- 433.139(b) (3) (i)                            (5)    The requirement for states to make payments without regard to potential TPL for pediatric preventive services unless the state has made a determination related to cost-effectiveness and access to care that warrants cost avoidance for 90 days.
- 433.139(b) (3) (ii) (B)                    (6)    State flexibility to make payments without regard to potential TPL for up to 100 days for claims related to child support enforcement beneficiaries.
- 42 CFR 447.20                                (e)    The Medicaid agency ensures that the provider furnishing a service for which a third party is liable follows the restrictions specified in 42 CFR 447.20.
- 55 FR 1423

TN No. SC 21-0015  
Supersedes  
TN No. MA 90-19

Approval Date

02/16/22

Effective Date 12/31/21  
HCFA ID: 1010P/0012P

Revision: HCFA-PM-91-8 (MB)  
October 1991

OMB No.: 0938-

State/Territory: South Carolina

Citation 4.22 (continued)

42 CFR 433.151(a) (f) The Medicaid agency has written cooperative agreements for the enforcement of rights to and collection of third party benefits assigned to the State as a condition of eligibility for medical assistance with at least one of the following: (Check as appropriate.)  
50 FR 46652

State title IV-D agency. The requirements of 42 CFR 433.152(b) are met.

Other appropriate State Agency(ies)--  
\_\_\_\_\_  
\_\_\_\_\_

Other appropriate State Agency(ies) of another State--  
\_\_\_\_\_  
\_\_\_\_\_

Courts and law enforcement officials.

42 CFR 433.151(b) (g) The Medicaid agency meets the requirements of 42 CFR 433.153 and 433.154 for making incentive payments and for distributing third party collections.  
50 FR 46652

1906 of the Act (h) The Medicaid agency specifies the guidelines used in determining the cost effectiveness of an employer-based group health plan by selecting one of the following.

The Secretary's method as provided in the State Medicaid Manual, Section 3910.

The State provides methods for determining cost effectiveness on Att. 4.22-C.

TN No. MA 93-011  
Supersedes  
TN No. N/A

Approval Date 11/05/93

Effective Date 10/01/93

HCFA ID: 0012

INTERAGENCY COOPERATIVE AGREEMENT  
BETWEEN THE STATE OF SOUTH CAROLINA  
DEPARTMENT OF SOCIAL SERVICES

AND

STATE HEALTH AND HUMAN SERVICES FINANCE COMMISSION

REGARDING DATA EXCHANGE BETWEEN  
THE OFFICE OF CHILD SUPPORT ENFORCEMENT

AND

THE THIRD PARTY LIABILITY DIVISION

I. AUTHORITY

This cooperative agreement is entered into under section 1902(a)(45) and 1912 of the Social Security Act as amended. These sections of the act are embodied in regulation at 45 CFR 306 and 45 CFR 433.151.

II. STATE HEALTH AND HUMAN SERVICES FINANCE COMMISSION RESPONSIBILITIES UNDER THIS AGREEMENT

- A. The Third Party Liability Section, State Health and Human Services Finance Commission, will maintain a file on each recipient identified as having health insurance coverage through a IV-D source and use the information provided by IV-D to pursue recoupment or cost avoidance of Medicaid expenditures for the affected individual.
- B. All Medicaid recoveries from health insurers will be made by the Third Party Liability Section, which has sole responsibility for setting priorities, limits and procedures for that recovery.
- C. Distribution of the state and federal portions of all Medicaid recoveries made as a result of IV-D will be made by the State Health and Human Services Finance Commission.
- D. The State Health and Human Services Finance Commission shall not refer cases to the IV-D section, Department of Social Services. However, the Commission shall inform the IV-D section of any case where health insurance ceases, that has been ordered by a court from an absent parent.
- E. The Third Party Liability Section will, on request, supply the IV-D section with information on Medicaid expenditures in cases

where the absent parent is ordered to make medical support, other than by providing insurance coverage.

III. DEPARTMENT OF SOCIAL SERVICES RESPONSIBILITIES UNDER THIS AGREEMENT

- A. The IV-D section, Department of Social Services, will petition the court to include medical coverage that is available to the absent parent at reasonable cost in any child support obligation.
- B. Information about any court ordered medical support for Medicaid recipients in the form of health or hospitalization insurance shall be forwarded to the Third Party Liability Section, Health and Human Services Finance Commission, for collection. In addition, the IV-D agency shall, as is convenient in the course of other contacts with the absent parent, investigate whether or not the absent parent carries health or hospitalization insurance not ordered by the court. Information or any coverage discovered shall be forwarded to the Third Party Liability Section. The IV-D agency shall not report negative findings. The data to be forwarded shall include:
  - 1. Name and Medicaid identification number for recipient(s) covered under the insurance,
  - 2. Whether or not insurance is court ordered.
  - 3. Name of absent parent,
  - 4. Type of insurance,
  - 5. Insurance company name,
  - 6. Policy number,
  - 7. Employer or group name and identification number, if any,and

8. Beginning date of coverage, if available.

C. The IV-D section shall be responsible for medical support enforcement activities whenever payment is to be made from the absent parent by means other than by providing health insurance coverage. Collections made by IV-D that are recoveries of Medicaid expenditures shall be routed to Health and Human Services Finance Commission for Federal and State distribution through the inter-departmental transfer process with identification of the source of payment, recipient name and identification number, medical provider and dates of service.

IV. COSTS OF DATA EXCHANGE

Neither party to this agreement shall reimburse the other party for any costs associated with the data exchange agreed to herein.

V. DURATION

This agreement will take effect upon signing by both parties. The terms of this agreement shall be five years from the date of the signature of both parties.

VI. CONFLICT WITH FEDERAL OR STATE STATUTES AND REGULATIONS

Should this agreement be found in conflict with Federal or State statutes or regulations, the statutes or regulations shall take precedence.

VII. SAFEGUARDING OF INFORMATION

The use or disclosure of information concerning applicants for or recipients of medical support enforcement services shall be limited to purposes directly connected with the performance of this Agreement.

In witness whereof, the Department of Social Services and the Health and Human Services Finance Commission do hereby agree to the terms and conditions of this Agreement as specified herein.

Date 12/20/85

Witness Mary K. Hornsby

//S//  
James L. Solomon, Commissioner  
Department of Social Services

Date 2/11/86

Witness Jean R. Avery

//S//  
Dennis Caldwell, Executive Director  
South Carolina Health and Human  
Services Finance Commission



Revision: HCFA-AT-84-2 (BERC)  
01-84

OMB No.: 0938-0193

State/Territory: South Carolina

Citation 4.23 Use of Contracts

42 CFR 434.4  
48 FR 54013

The Medicaid agency has contracts of the type(s) listed in 42 CFR Part 434. All contracts meet the requirements of 42 CFR Part 434.

Not applicable. The State has no such contracts.

42 CFR Part 438

The Medicaid agency has contracts of the type(s) listed in 42 CFR part 438. All contracts meet the requirements of 42 CFR Part 438. Risk contracts are entered into with any eligible and qualified MCOs. The risk contract is with (check all that apply):

A Managed Care Organization that meets the definition of 1903(m) of the Act and 42 CFR 438.2.

A Prepaid Inpatient Health Plan that meets the definition of 42 CFR 438.2.

A Prepaid Ambulatory Health Plan that meets the definition of 42 CFR 438.2.

Not applicable.

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TN No. MA 04-002  
Supersedes  
TN No. MA 03-011

Approval Date 04/01/04

Effective Date 06/10/04

Revision: HCFA-PM-94-2 (BPD)  
APRIL 1994

State/Territory: South Carolina

<p><u>Citation</u> 42 CFR 442.10 and 442.100 AT-78-90 AT-79-18 AT-80-25 AT-80-34 52 FR 32544 P.L. 100-203 (Sec. 4211) 54 FR 5316 56 FR 48826</p>	<p>4.24 <u>Standards for Payments for Nursing Facility and Intermediate Care Facility for the Mentally Retarded Services</u></p> <p>With respect to nursing facilities and intermediate care facilities for the mentally retarded, all applicable requirements of 42 CFR Part 442, Subparts B and C are met.</p> <p>_____ Not applicable to intermediate care facilities for the mentally retarded; such services are not provided under this plan.</p>
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TN No. MA 94-004  
Supersedes  
TN No. 80-08

Approval Date 06/14/94

Effective Date 4/01/94

Revision: HCFA-AT-80-38 (BPP)  
May 22, 1980

State: \_\_\_\_\_ South Carolina \_\_\_\_\_

Citation  
42 CFR 431.702  
AT-78-90

4.25 Program for Licensing Administrators of Nursing Homes

The State has a program that, except with respect to Christian Science sanatoria, meets the requirements of 42 CFR Part 431, Subpart N, for the licensing of nursing home administrators.

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TN No. 73-11  
Supersedes \_\_\_\_\_  
TN No. \_\_\_\_\_

Approval Date 05/16/74

Effective Date 12/31/73

Revision: HCFA-PM- (MB)

State/Territory: South Carolina

- Citation 4.26 Drug Utilization Review Program  
 1927(g) A.1. The Medicaid agency meets the requirements of  
 42 CFR 456.700 Section 1927 (g) of the Act for a drug use  
 review (DUR) program for outpatient drug claims.
- 1927(g) (1) (A) 2. The DUR program assures that prescriptions for  
 outpatient drugs are:  
 -Appropriate  
 -Medically necessary  
 -Are not likely to result in adverse medical  
 results
- 1927(g) (1) (a)  
 42 CFR 456.705(b) and  
 456.709(b) B. The DUR Program is designed to educate  
 physicians and pharmacists to identify and  
 reduce the frequency of patterns of fraud,  
 abuse, gross overuse, or inappropriate or  
 medically unnecessary care among physicians,  
 pharmacists, and patients or associated with  
 specific drugs as well as:  
 -Potential and actual adverse drug reactions  
 -Therapeutic appropriateness  
 -Overutilization and underutilization  
 -Appropriate use of generic products  
 -Therapeutic duplication  
 -Drug disease contraindications  
 -Drug-drug interactions  
 -Incorrect drug dosage or duration of drug  
 treatment  
 -Drug-allergy interactions  
 -Clinical abuse/misuse
- 1927(g) (1) (B)  
 42 CFR 456.703  
 (d) and (f) C. The DUR program shall assess data use against  
 predetermined standards whose source materials  
 for their development are consistent with peer-  
 reviewed medical literature which has been  
 critically reviewed by unbiased independent  
 experts and the following compendia:  
 -American Hospital Formulary Service Drug  
 Information  
 -United States Pharmacopeia-Drug Information  
 -American Medical Association Drug Evaluations

TN No. MA 93-008  
 Supersedes  
 TN No. MA 93-003

Approval Date 07/30/93Effective Date 04/01/93

Revision: HCFA-PM- (MB)  
 State/Territory: South Carolina

Citation

1927(g) (1) (D)  
 42 CFR 456.703(b)

D. DUR is not required for drugs dispensed to residents of nursing facilities that are in compliance with drug regimen review procedures set forth in 42 CFR 483.60. The State has never-the-less chosen to include nursing home drugs in:

       Prospective DUR  
  X   Retrospective DUR.

1927(g) (2) (A)  
 42 CFR 456.705(b)

E.1. The DUR program includes prospective review of drug therapy at the point of sale or point of distribution before each prescription is filled or delivered to the Medicaid recipient.

1927(g) (2) (A) (i)  
 42 CFR 456.705(b),  
 (1) - (7)

2. Prospective DUR includes screening each prescription filled or delivered to an individual receiving benefits for potential drug therapy problems due to:

- Therapeutic duplication
- Drug-disease contraindications
- Drug-drug interactions
- Drug-interactions with non-prescription or over-the-counter drugs
- Incorrect drug dosage or duration of drug treatment
- Drug allergy interactions
- Clinical abuse/misuse

1927(g) (2) (A) (ii)  
 42 CFR 456.705(c)  
 and (d)

3. Prospective DUR includes counseling for Medicaid recipients based on standards established by State law and maintenance of patient profiles.

1927(g) (2) (B)  
 42 CFR 456.709(a)

F.1. The DUR program includes retrospective DUR through its mechanized drug claims processing and information retrieval system or otherwise which undertakes ongoing periodic examination of claims data and other records to identify:

- Patterns of fraud and abuse
- Gross overuse
- Inappropriate or medically unnecessary care among physicians, pharmacists, Medicaid recipients, or associated with specific drugs or groups of drugs.

TN No. MA 93-008  
 Supersedes  
 TN No. MA 93-003

Approval Date 07/30/93

Effective Date 04/01/93

Revision: HCFA-PM- (MB)

State/Territory: South CarolinaCitation

- 927(g) (2) (C)  
42 CFR 456.709(b)
- F.2. The DUR program assesses data on drug use against explicit predetermined standards including but not limited to monitoring for:
- Therapeutic appropriateness
  - Overutilization and underutilization
  - Appropriate use of generic products
  - Therapeutic duplication
  - Drug-disease contraindications
  - Drug-drug interactions
  - Incorrect drug dosage/duration of drug treatment
  - Clinical abuse/misuse
- 1927(g) (2) (D)  
42 CFR 456.711
3. The DUR program through its State DUR Board, using data provided by the Board, provides for active and ongoing educational outreach programs to educate practitioners on common drug therapy problems to improve prescribing and dispensing practices.
- 1927(g) (3) (A)  
42 CFR 456.716(a)
- G.1. The DUR program has established a State DUR Board either:
- Directly, or
  - Under contract with a private organization
- 1927(g) (3) (B)  
42 CFR 456.716  
(A) and (B)
2. The DUR Board membership includes health professionals (one-third licensed actively practicing pharmacists and one-third but no more than 51 percent licensed and actively practicing physicians) with knowledge and experience in one or more of the following:
- Clinically appropriate prescribing of covered outpatient drugs.
  - Clinically appropriate dispensing and monitoring of covered outpatient drugs.
  - Drug use review, evaluation and intervention.
  - Medical quality assurance.
- 927(g) (3) (C)  
42 CFR 456.716(d)
3. The activities of the DUR Board include:
- Retrospective DUR,
  - Application of Standards as defined in section 1927(g) (2) (C), and
  - Ongoing interventions for physicians and pharmacists targeted toward therapy problems or individuals identified in the course of retrospective DUR.

TN No. MA 93-008

Supersedes

TN No. MA 93-003Approval Date 07/30/93Effective Date 04/01/93

Revision: HCFA-PM- (MB)

State/Territory: South CarolinaCitation

- 1927(g) (3) (C)  
42 CFR 456.711  
(a)-(d)
- G.4. The interventions include in appropriate instances:
- Information dissemination
  - Written, oral, and electronic reminders
  - Face-to-Face discussions
  - Intensified monitoring/review of prescribers/dispensers
- 1927(g) (3) (D)  
42 CFR 456.712  
(A) and (B)
- H. The State assures that it will prepare and submit an annual report to the Secretary, which incorporates a report from the State DUR Board, and that the State will adhere to the plans, steps, procedures as described in the report.
- 1927(h) (1)  
42 CFR 456.722
- I.1. The State establishes, as its principal means of processing claims for covered outpatient drugs under this title, a point-of-sale electronic claims management system to perform on-line:
- real time eligibility verification
  - claims data capture
  - adjudication of claims
  - assistance to pharmacists, etc. applying for and receiving payment.
- 1927(g) (2) (A) (i)  
42 CFR 456.705(b)
2. Prospective DUR is performed using an electronic point of sale drug claims processing system.
- 1927(j) (2)  
42 CFR 456.703(c)
- J. Hospitals which dispense covered outpatient drugs are exempted from the drug utilization review requirements of this section when facilities use drug formulary systems and bill the Medicaid program no more than the hospital's purchasing cost for such covered outpatient drugs.

TN No. MA 93-008

Supersedes

TN No. N/AApproval Date 07/30/93Effective Date 04/01/93

Revision: HCFA-PM- (MB)

State/Territory: South CarolinaCitation

1902(a) (85) and  
Section 1004  
of the Substance  
Use-Disorder  
Prevention that  
Promotes Opioid  
Recovery and Treatment  
for Patients  
and Communities Act  
(SUPPORT Act)

K. South Carolina Medicaid has fully implemented Section 1004 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act (P.L. 115-271). The State is in compliance with the new drug review and utilization requirements set forth in section 1902(a) (85) of the Act, as follows:

## 1. Claims Review Requirements

## A. Safety Edits Including Early, Duplicate, and Quantity Limits

i. The state has implemented the following prospective opioid safety edits:

- (1) Quantity limits, including days' supply Limits
- (2) Length of therapy limits
- (3) Refill frequency (percent to refill) limits
- (4) Duplicate fills
- (5) Maximum Morphine Milligram Equivalents (MME)/Day limits

ii. The state has implemented the following retrospective opioid safety reviews:

- (1) Quantity limits, including days' supply limits
- (2) Length of therapy limits
- (3) Refill frequency (percent to refill) limits
- (4) duplicate fills
- (5) maximum MME/day reviews

## B. Concurrent Utilization Alerts

i. Opioid and Benzodiazepines Current Fill Reviews

- (1) The state has implemented and monitors results of prior authorization requirements for concomitant opioids and benzodiazepines

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 TN No. SC 19-0006

Supersedes

10/01/19TN No. New PageApproval Date 03/13/2020

Effective Date



Revision: HCFA-PM- (MB)

State/Territory: South Carolina

## ii. Opioid and Antipsychotic Concurrent Fill Reviews

(1) The state has implemented and monitors results of DUR edits

## 2. Program to Monitor Antipsychotic Medications by Children

A. The state has implemented and monitors results of the following:

i. age restrictions

ii. quantity limits

iii. Prior authorization requirements for duplicate antipsychotic therapy

iv. Department of Child Services Psychotropic Medications report

## 3. Fraud and Abuse Identification Requirements

A. The state has implemented and monitors results including but not necessarily limited to the following:

i. limits on number of opioid prescribers over a period of time

ii. prior authorization requirements for concomitant opioid and buprenorphine-based substance use disorder treatment

iii. Ad hoc PDMP reviews corresponding to prior authorization requests

iv. Pharmacy claims audits

TN No. SC 19-0006  
Supersedes  
10/01/19  
TN No. New Page

Approval Date 03/13/2020

Effective Date

Revision: HCFA-AT-80-38 (BPP)  
May 22, 1980

State: South Carolina

Citation  
42 CFR 431.115(c)  
AT-78-90  
AT-79-74

4.27 Disclosure of Survey Information and Provider or Contractor Evaluation

The Medicaid agency has established procedures for disclosing pertinent findings obtained from surveys and provider and contractor evaluations that meet all the requirements in 42 CFR 431.115.

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TN No. 79-15  
Supersedes  
TN No. \_\_\_\_\_

Approval Date 01/17/80

Effective Date 12/31/79

Revision: HCFA-PM-93-1 (BPD)  
January 1993

State/Territory: South Carolina

Citation

4.28 Appeals Process

42 CFR 431.152  
AT-79-18  
52 FR 22444;  
Secs.

1902 (a) (28) (D) (i)  
and 1919(e) (7) of  
the Act; P.L.  
100-203 (Sec. 4211(c))

- (a) The Medicaid agency has established appeals procedures for NFs as specified in 42 CFR 431.153 and 431.154.
- (b) The State provides an appeals system that meets the requirements of 42 CFR 431 Subpart E, 42 CFR 483.12 and 42 CFR 483 Subpart E for residents who wish to appeal a notice of intent to transfer or discharge from a NF and for individuals adversely affected by the preadmission and annual resident review requirements of 42 CFR 483 Subpart C.

TN No. MA 93-009

Supersedes

TN No. MA 88-17

Approval Date 07/12/93

Effective Date 04/01/93

Revision: HCFA-PM-99-3  
JUNE 1999

State: South Carolina

Citation

1902(a) (4) (C) of the  
Social Security Act  
P.L. 105-33

4.29 Conflict of Interest Provisions

The Medicaid agency meets the requirements of Section 1902(a) (4) (C) of the Act concerning the Prohibition against acts, with respect to any activity under the plan, that is prohibited by section 207 or 208 of this title 18, United States Code.

1902(a) (4) (D) of the  
Social Security Act  
P.L. 105-33  
are at  
1932(d) (3)  
42 CFR 438.58

The Medicaid agency meets the requirements of 1902(a) (4) (D) of the Act concerning the safeguards against conflicts of interest that least as stringent as the safeguards that apply under section 27 of the Office of Federal Procurement Policy Act (41 U.S.C. 423).

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TN No. MA 03-011  
Supersedes  
TN No. MA 88-017

Approval Date 11/06/03

Effective Date 08/13/03

Revision: HCFA-PM-87-14 (BERC)  
OCTOBER 1987

OMB No.: 0938-0193

State: South Carolina

Citation  
42 CFR 1002.203  
AT-79-54  
48 FR 3742  
51 FR 34772

4.30 Execution of Providers and Suspension of Practitioners and Other Individuals

(a) All requirements of 42 CFR Part 1002, Subpart B are met.

The agency, under the authority of State law, imposes broader sanctions.

TN No. MA 88-02  
Supersedes  
TN No. MA-87-16

Approval Date 02/23/88

Effective Date 01/01/88

Revision: HCFA-AT-87-14 (BERC)  
OCTOBER 1987

OMB No.: 0938-0193

State/Territory: South Carolina

- Citation (b) The Medicaid agency meets the requirements of -
- 1902(p) of the Act (1) Section 1902(p) of the Act by excluding from participation--
- (A) At the State's discretion, any individual or entity for any reason for which the Secretary could exclude the individual or entity from participation in a program under Title XVIII in accordance with sections 1128, 1128A, or 1866(b) (2).
- 42 CFR 438.808 (B) An MCO (as defined in section 1903(m) of the Act), or an entity furnishing services under a waiver approved under section 1915(b) (1) of the Act, that--
- (i) Could be excluded under section 1128(b) (8) relating to owners and managing employees who have been convicted of certain crimes or received other sanctions, or
- (ii) Has, directly or indirectly, a substantial contractual relationship (as defined by the Secretary) with an individual or entity that is described in section 1128(b) (8) (B) of the Act.
- 1932(d) (1) (2) An MCO, PIHP, PAHP, or PCCM may not have  
42 CFR 438.610 prohibited affiliations with individuals (as defined in 42 CFR 438.610(b)) suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549. If the State finds that an MCO, PCCM, PIPH, or PAHP is not in compliance, the State will comply with the requirements of 42 CFR 438.610(c).

TN No. MA 03-011

Supersedes

TN No. MA 88-002

Approval Date 11/06/03

Effective Date 08/13/03

Revision: HCFA-AT-87-14 (BERC)  
OCTOBER 1987

OMB No.: 0938-0193  
4.30 Continued

State/Territory: South Carolina

Citation

- 1902(a) (39) of the Act (2) Section 1902(a) (39) of the Act by--  
P.L. 100-93  
(Sec. 8(f))
- (A) Excluding an individual or entity from participation for the period specified by the Secretary, when required by the Secretary to do so in accordance with sections 1128 or 1128A of the Act; and
- (B) Providing that no payment will be made with respect to any item or service furnished by an individual or entity during this period.
- (c) The Medicaid agency meets the requirements of--
- 1902(a) (41) of the Act (1) Section 1902(a) (41) of the Act with respect to prompt notification to HCFA whenever a provider is terminated, suspended, sanctioned , or otherwise excluded from participating under this State plan; and  
P.L. 96-272,  
(sec. 308(c))
- 1902(a) (49) of the Act (2) Section 1902(a) (49) of the Act with respect to providing information and access to information regarding sanctions taken against health care practitioners and providers by State licensing authorities in accordance with Section 1921 of the Act.  
P.L. 100-93  
(sec. 5(a) (4))

TN No. MA 88-02

Supersedes

TN No. N/A

Approval Date 02/23/88

Effective Date 01/01/88

HCFA ID: 1010P/0012P

## STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: South CarolinaCitation

455.103  
44 FR 41644  
1902(a) (38)  
of the Act  
P.L. 100-93  
(sec. 8(f))

4.31 Disclosure of Information by Providers and Fiscal Agents

The Medicaid agency has established procedures for the disclosure of information by providers and fiscal agents as specified in 42 CFR 455.104 through 455.106 and sections 1128(b) (9) and 1902(a) (38) of the Act.

435.940  
through 435.960  
42 CFR

4.32 Income and Eligibility Verification System

(a) The Medicaid agency has established a system for income and eligibility verification in accordance with the requirements of 42 CFR 435.940 through 435.960. (Section 1137 of the Act and 42 CFR 435.940 through 435.960.)

(b) ATTACHMENT 4.32-A describes, in accordance with 42 CFR 435.948(a) (6), the information that will be requested in order to verify eligibility or the correct payment amount and the agencies and the State(s) from which that information will be requested.

(c) The State has an eligibility determination system that provides for data matching through the Public Assistance Reporting Information System (PARIS), or any successor system, including matching with medical assistance programs operated by other States. The information that is requested will be exchanged with States and other entities legally entitled to verify title XIX applicants and individuals eligible for covered title XIX services consistent with applicable PARIS agreements.

SCDHHS transmits quarterly, a file of Medicaid applicants and recipients and non-applying members in active and pending budget groups to the Defense Manpower Data Center (DMDC). DMDC provides computer support services for the PARIS Project. DMDC matches this file with data from other participating states, as well as the Veteran's Administration and the Department of Defense.

TN No. SC 10-002  
Supersedes  
TN No. MA 88-02

Approval Date 09/23/10Effective Date 04/01/10



## STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: South Carolina

Currently SCDHHS has a signed agreement to receive the data matches with other states. There are no current signed agreements to receive VA and Department of Defense matches. Note: These agreements cannot be signed until DHHS is able to determine that the MEDS Security protocols are consistent with those set by the U.S. Department of Commerce, National Institute of Standards and Technology (NIST) Publication 800-53, Revision 1.

## Interstate Matches:

A response file is returned to DHHS that identifies Medicaid applicants and recipients who are receiving or have received Medicaid, TANF, SNAP, SSI, General Assistance, Workers Compensation, or child care in more than one participating state for the same period. The DHHS Medicaid Eligibility Determination System (MEDS) processes the incoming response file and makes the information received available through online screens. Eligibility workers are alerted to verify the whereabouts of the recipient during the overlapping period and terminate the Medicaid, if appropriate. At this time, the agencies that administer TANF, SNAP, General Assistance, Worker Compensation and Child Care do not participate, although there have been some requests for information from the Department of Social Services (TANF, SNAP, General Assistance, Child Care).

## Veteran's Administration:

The match with the Veteran's Administration would identify persons receiving VA compensation and pensions. This information would be made available to the worker for eligibility determinations and reviews. Workers would be alerted to determine if the receipt of VA compensation and benefits impacts the eligibility decision.

## Department of Defense:

The match with the Department of Defense would identify persons receiving Federal employee wages and pensions. This includes wages for active and retired military personnel and active and retired non-postal Federal civilian employees. This information would be made available to the worker for eligibility determinations and reviews. Workers would be alerted to determine if the receipt of federal wages and pensions impacts the eligibility decision.

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 TN No. SC 10-002

Supersedes

Approval Date 09/23/10Effective Date 04/01/10TN No. New Page

Revision: HCFA-PM-88-10 (BERC)  
SEPTEMBER 1988

OMB No.: 0938-0193

State/Territory: South Carolina

Citation  
1137 of  
the Act

P.L. 99-603  
(sec. 121)

4.34 Systematic Alien Verification for Entitlement  
The State Medicaid agency has established procedures for the verification of alien status through the Immigration & Naturalization Service (INS) designated system, Systematic Alien Verification for Entitlements (SAVE), effective October 1, 1988.

The State Medicaid agency has elected to participate in the option period of October 1, 1987 to September 30, 1988 to verify alien status through the INS designated system (SAVE).

The State Medicaid agency has received the following type(s) of waiver from participation in SAVE.

- Total waiver
- Alternative system
- Partial implementation

TN No. MA 88-17  
Supersedes  
TN No. N/A (new)

Approval Date 01/09/89

Effective Date 01/01/89

HCFA ID: 1010P/0012P

Revision: HCFA-PM-90-2 (BPD)  
 JANUARY 1990

OMB No.: 0938-0193

State/Territory: South Carolina

Citation

4.35 Remedies for Skilled Nursing and Intermediate Care Facilities that Do Not Meet Requirements of Participation

1919(h) (1)  
 and (2)  
 of the Act,  
 P.L. 100-203  
 (Sec. 4213(a))

(a) The Medicaid agency meets the requirements of section 1919(h) (2) (A) through (D) of the Act concerning remedies for skilled nursing and intermediate care facilities that do not meet one or more requirements of participation. ATTACHMENT 4.35-A describes the criteria for applying the remedies specified in section 1919(h) (2) (A) (i) through (iv) of the Act.

Not applicable to intermediate care facilities; these services are not furnished under this plan.

(b) The agency uses the following remedy(ies):

(1) Denial of payment for new admissions.

(2) Civil money penalty.

(3) Appointment of temporary management.

(4) In emergency cases, closure of the facility and/or transfer of residents.

1919(h) (2) (B) (ii)   
 of the Act

(c) The agency establishes alternative State remedies to the specified Federal remedies (except for termination of participation). ATTACHMENT 4.35-B describes these alternative remedies and specifies the basis for their use.

1919(h) (2) (F)  
 of the Act

(d) The agency uses one of the following incentive programs to reward skilled nursing or intermediate care facilities that furnish the highest quality care to Medicaid residents:

(1) Public recognition.

(2) Incentive payments.

TN No. MA 90-20  
 Supersedes  
 TN No. N/A

Approval Date 09/07/90

Effective Date 10/01/90

HCFA ID: 1010P/0012P

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

State/Territory: South Carolina

Citation 4.35 Enforcement of Compliance for Nursing Facilities

42 CFR  
§488.402(f)

(a) Notification of Enforcement Remedies

When taking an enforcement action against a non-State operated NF, the State provides notification in accordance with 42 CFR 488.402(f).

(i) The notice (except for civil money penalties and State monitoring) specifies the:

- (1) nature of noncompliance,
- (2) which remedy is imposed,
- (3) effective date of the remedy, and
- (4) right to appeal the determination leading to the remedy.

42 CFR  
§488.434

(ii) The notice for civil money penalties is in writing and contains the information specified in 42 CFR 488.434.

42 CFR  
§488.402(f)(2)

(iii) Except for civil money penalties and State monitoring, notice is given at least 2 calendar days before the effective date of the enforcement remedy for immediately jeopardy situations and at least 15 calendar days before the effective date of the enforcement remedy when immediate jeopardy does not exist.

42 CFR  
§488.456(c)(d)

(iv) Notification of termination is given to the facility and to the public at least 2 calendar days before the remedy's effective date if the noncompliance constitutes immediate jeopardy and at least 15 calendar days before the remedy's effective date if the noncompliance does not constitute immediate jeopardy. The State must terminate the provider agreement of an NF in accordance with procedures in parts 431 and 442.

(b) Factors to be Considered in Selecting Remedies

42 CFR  
§488.488.404(b)(1)

(i) In determining the seriousness of deficiencies, the State considers the factors specified in 42 CFR 488.404(b)(1) & (2).

\_\_\_\_\_ The State considers additional factors. ATTACHMENT 4.35-A describes the State's other factors.

TN No. MA 99-001  
Supersedes  
TN No. N/A

Approval Date 06/21/99

Effective Date 04/01/99

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

State/Territory: South Carolina

Citation

(c) Application of Remedies

- 42 CFR §488.410 (i) If there is immediate jeopardy to resident health or safety, the State terminates the NF's provider agreement within 23 calendar days from the date of the last survey or immediately imposes temporary management to remove the threat within 23 days.
- 42 CFR §488.417(b) (ii) The State imposes the denial of payment (or its approved alternative) with respect to any individual admitted to an NF that has not come into substantial compliance within 3 months after the last day of the survey.
- §1919(h) (2) (C) of the Act.
- 42 CFR §488.414 (iii) The State imposes the denial of payment for new admissions remedy as specified in §488.417 (or its approved alternative) and a State monitor as specified at §488.422, when a facility has been found to have provided substandard quality of care on the last three consecutive standard surveys.
- §1919(h) (2) (D) of the Act.
- 42 CFR §488.408 (iv) The State follows the criteria specified at 42 CFR §488.408(c) (2), §488.408(d) (2), and §488.408(e) (2), when it imposes remedies in place of or in addition to termination.
- 1919(h) (2) (A) of the Act.
- 42 CFR §488.412(a) (v) When immediate jeopardy does not exist, the State terminates an NF's provider agreement no later than 6 months from the finding of noncompliance, if the conditions of 42 CFR 488.412(a) are met.

(d) Available Remedies

- 42 CFR §488.406(b) (i) The State has established the remedies defined in 42 CFR 488.406(b).
  - X (1) Termination
  - X (2) Temporary Management
  - X (3) Denial of Payment for New Admissions
  - X (4) Civil Money Penalties
  - X (5) Transfer of Residents; Transfer of Residents with Closure of Facility
  - X (6) State Monitoring
- §1919(h) (2) (A) of the Act.

Attachments 4.35-B through 4.35-G describe the criteria for applying the above remedies.

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JUNE 1995

State/Territory: South Carolina

Citation

42 CFR (ii) \_\_\_\_\_ The State uses alternative remedies.  
§488.406(b) The State has established alternative  
§1919(h)(2)(B)(ii) remedies that the State will impose in  
of the Act. place of a remedy specified in 42 CFR  
488.406(b).

- \_\_\_\_\_ (1) Temporary Management
- \_\_\_\_\_ (2) Denial of Payment for New Admissions
- \_\_\_\_\_ (3) Civil Money Penalties
- \_\_\_\_\_ (4) Transfer of Residence; Transfer of Residents with Closure of Facility
- \_\_\_\_\_ (5) State Monitoring.

Attachments 4.35-B through 4.35-G describe the alternative remedies and the criteria for applying them.

42CFR (e) \_\_\_\_\_ State Incentive Programs  
§488.303(b) \_\_\_\_\_ (1) Public Recognition  
1910(h)(2)(F) \_\_\_\_\_ (2) Incentive Payments  
of the Act.

TN No. MA 99-001  
Supersedes  
TN No. N/A

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Effective Date 04/01/99

Revision: HCFA-PM-91-4 (BPD)  
AUGUST 1991

OMB No.: 0938-

State/Territory: South Carolina

Citation 4.36 Required Coordination Between the Medicaid and WIC Programs

1902(a)(11)(C)  
and 1902(a)(53)  
of the Act

The Medicaid agency provides for the coordination between the Medicaid program and the Special Supplemental Food program for Women, Infants, and Children (WIC) and provides timely notice and referral to WIC in accordance with section 1902(a)(53) of the Act.

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Supersedes  
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Effective Date 01/01/92

HCFA ID: 7982E

Revision: HCFA-PM-91-10 (BPD)  
December 1991

State/Territory: South Carolina

<p><u>Citation</u> 42 CFR 483.75; 42 CFR 483 Subpart D; Secs. 1902(a)(28), 1919(e)(1) and (2), and 1919(f)(2), P.L. 100-203 (Sec. 4211(a)(3)); P.L. 101-239 (Secs. 6901(b)(3) and (4)); P.L. 101-508 (Sec. 4801(a)).</p>	<p>4.38 <u>Nurse Aide Training and Competency Evaluation For Nursing Facilities</u></p> <p>(a) The State assures that the requirements of 42 CFR 483.150(a), which relate to individuals deemed to meet the nurse aide training and competency evaluation requirements, are met.</p> <p><u>X</u> (b) The State waives the competency evaluation requirements for individuals who meet the requirements of 42 CFR 483.150(b)(1).</p> <p><u>X</u> (c) The State deems individuals who meet the requirements of 42 CFR 483.150(b)(2) to have met the nurse aide training and competency evaluation requirements.</p> <p>(d) The State specifies any nurse aide training and competency evaluation programs it approves as meeting the requirements of 42 CFR 483.152 and competency evaluation programs it approves as meeting the requirements of 42 CFR 483.154.</p> <p><u>X</u> (e) The State offers a nurse aide training and competency evaluation program that meets the requirements of 42 CFR 483.152.</p> <p><u>X</u> (f) The State offers a nurse aide competency evaluation program that meets the requirements of 42 CFR 483.154.</p>
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TN No. MA 92-05  
Supersedes  
TN No. N/A

Approval Date 04/07/92

Effective Date 04/01/92



Revision: HCFA-PM-91-10 (BPD)  
DECEMBER 1991

State/Territory: South Carolina

Citation

42 CFR 483.75; 42 CFR 483 Subpart D; Secs. 1902(a)(28), 1919(e)(1) and (2), and 1919(f)(2), P.L. 100-203 (Sec. 4211(a)(3)); P.L. 101-239 (Secs. 6901(b)(3) and (4)); P.L. 101-508 (Sec. 4801(a)).

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- (g) If the State does not choose to offer a nurse aide training and competency evaluation program or nurse aide competency evaluation program, the State reviews all nurse aide training and competency evaluation programs and competency evaluation programs upon request.
- (h) The State survey agency determines, during the course of all surveys, whether the requirements of 483.75(e) are met.
- (i) Before approving a nurse aide training and competency evaluation program, the State determines whether the requirements of 42 CFR 483.152 are met.
- (j) Before approving a nurse aide competency evaluation program, the State determines whether the requirements of 42 CFR 483.154 are met.
- (k) For program reviews other than the initial review, the State visits the entity providing the program.
- (l) The State does not approve a nurse aide training and competency evaluation program or competency evaluation program offered by or in certain facilities as described in 42 CRR 483.151(b)(2) and (3).

TN No. MA 92-05  
Supersedes  
TN No. N/A

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Revision: HCFA-PM-91-10 (BPD)  
 DECEMBER 1991

State/Territory: South Carolina

<p><u>Citation</u>          42 CFR 483.75; 42          CFR 483 Subpart D;          Secs. 1902(a) (28),          1919(e) (1) and (2),          and 1919(f) (2),  <u>X</u> P.L. 100-203 (Sec.          4211(a) (3); P.L.          101-239 (Secs.          6901(b) (3) and          (4); P.L. 101-508          (Sec. 4801(a)).</p>	<p>(z) The State includes a record of successful completion of a competency evaluation within 30 days of the date an individual is found competent.</p> <p>(aa) The State imposes a maximum upon the number of times an individual may take a competency evaluation program (any maximum imposed is not less than 3).</p> <p>(bb) The State maintains a nurse aide registry that meets the requirements in 42 CFR 483.156.</p> <p>___ (cc) The State includes home health aides on the registry.</p> <p>___ (dd) The State contacts the operation of the registry to a non State entity.</p> <p><u>X</u> (ee) <u>ATTACHMENT 4.38</u> contains the State's description of registry information to be disclosed in addition to that required in 42 CFR 483.156(c) (1) (iii) and (iv).</p> <p><u>X</u> (ff) <u>ATTACHMENT 4.38-A</u> contains the State's description of information included on the registry in addition to the information required by 42 CFR 483.156(c).</p>
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TN No. MA 92-05  
 Supersedes  
 TN No. N/A

Approval Date 04/07/92

Effective Date 04/01/92

Revision: HCFA-PM-93-1 (BPD)  
 JANUARY 1993

State/Territory: South Carolina

<p><u>Citation</u>          Secs.          1902(a)(28)(D)(i)          and 1919(e)(7) of          the Act;          P.L. 100-203          (Sec. 4211(c));          P.L. 101-508          (Sec. 4801(b)).</p>	<p>4.39 <u>Preadmission Screening and Annual Resident Review in Nursing Facilities</u></p> <p>(a) The Medicaid agency has in effect a written agreement with the State mental health and mental retardation authorities that meet the requirements of 42 (CFR) 431.621(c).</p> <p>(b) The State operates a preadmission and an annual resident review program that meets the requirements of 42 CFR 483.100-138.</p> <p>(c) The State does not claim as "medical assistance under the State Plan" the cost of services to individuals who should receive preadmission screening or annual resident review until such individuals are screened or reviewed.</p> <p>(d) With the exception of NF services furnished to certain NF residents defined in 42 CFR 483.118 (c)(1), the States does not claim as "medical assistance under the State plan" the cost of NF services to individuals who are found not to require NF services.</p>	<p><u>X</u> (e) <u>ATTACHMENT 4.39</u> specifies the State's definition of specialized services.</p>
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TN No. MA 93-009  
 Supersedes  
 TN No. N/A

Approval Date 07/12/93

Effective Date 04/01/93

Revision: HCFA-PM-93-1 (BPD)  
January 1993

State/Territory: South Carolina

4.39 (Continued)

- (f) Except for residents identified in 42 CFR 483.118(c)(1), the State mental health or mental retardation authority makes categorical determinations that individuals with certain mental conditions or levels of severity of mental illness would normally require specialized services of such an intensity that a specialized services program could not be delivered by the State in most, if not all, NF's and that a more appropriate placement should be utilized.
- (g) The State describes any categorical determinations it applies in ATTACHMENT 4.39-A.

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TN No. MA 93-009  
Supersedes  
TN No. N/A

Approval Date 07/12/93

Effective Date 04/01/93

Revision: HCFA-PM-92-3 (HSQB)  
April 1992

OMB. No.:

State/Territory: South Carolina

Citation

4.40 Survey & Certification Process

Sections

1919(g) (1)  
thru (2) and  
1919(g) (4)  
thru (5) of  
the Act P.L.  
100-203  
(Sec.  
4212(a))

(a) The State assures that the requirements of 1919(g) (1) (A) through (C) and section 1919(g) (2) (A) through (E) (iii) of the Act which relate to the survey and certification of non-State owned facilities based on the requirements of section 1919(b), (c) and (d) of the Act, are met.

1919(g) (1)  
(B) of the  
Act

(b) The State conducts periodic education programs for staff and residents (and their representatives). ATTACHMENT 4.40-A describes the survey and certification educational program.

1919(g) (1)  
(C) of the  
Act

(c) The State provides for a process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property by a nurse aide of a resident in a nursing facility or by another individual used by the facility. ATTACHMENT 4.40-B describes the State's process.

1919(g) (1)  
(C) of the  
Act

(d) The State agency responsible for surveys and certification of nursing facilities or an agency delegated by the State survey agency conducts the process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property. If not the State survey agency, what agency?

1919(g) (1)  
(C) of the  
Act

(e) The State assures that a nurse aide, found to have neglected or abused a resident or misappropriated resident property in a facility, is notified of the finding. The name and finding is placed on the nurse aide registry.

1919(g) (1)  
(C) of the  
Act

(f) The State notifies the appropriate licensure authority of any licensed individual found to have neglected or abused a resident or misappropriated resident property in a facility.

TN No. MA 92-11

Supersedes

Approval Date 02/17/93

Effective Date 07/01/92

TN No. N/A

HCFA ID: \_\_\_\_\_

Revision: HCFA-PM-92-3  
APRIL 1992

(HSQB)

OMB No.:

State/Territory: South Carolina

- 1919(g) (2)  
(A) (i) of  
the Act
- (g) The State has procedures, as provided for at section 1919(g) (2) (A) (i), for the scheduling and conduct of standard surveys to assure that the State has taken all reasonable steps to avoid giving notice through the scheduling procedures and the conduct of the surveys themselves. ATTACHMENT 4.40-C describes the State's procedures.
- 1919(g) (2)  
(A) (ii) of  
the Act
- (h) The State assures that each facility shall have a standard survey which includes (for a case-mix stratified sample of residents) a survey of the quality of care furnished, as measured by indicators of medical, nursing and rehabilitative care, dietary and nutritional services, activities and social participation, and sanitation, infection control, and the physical environment, written plans of care and audit of resident's assessments, and a review of compliance with resident's rights not later than 15 months after the date of the previous standard survey.
- 1919(g) (2)  
(A) (iii) (I)  
of the Act
- (i) The State assures that the Statewide average interval between standard surveys of nursing facilities does not exceed 12 months.
- 1919(g) (2)  
(A) (iii) (II)  
of the Act
- (j) The State may conduct a special standard or special abbreviated standard survey within 2 months of any change of ownership, administration management, or director of nursing of the nursing facility to determine whether the change has resulted in any decline in the quality of care furnished in the facility.
- 1919(g) (2)  
(B) of the  
Act
- (k) The State conducts extended surveys immediately or, if not practicable, not later than 2 weeks following a completed standard survey in a nursing facility which is found to have provided substandard care or in any other facility at the Secretary's or State's discretion.
- 1919(g) (2)  
(C) of the  
Act
- (l) The State conducts standard and extended surveys based upon a protocol, i.e., survey forms, methods, procedures and guidelines developed by HCFA, using individuals in the survey team who meet minimum qualifications established by the Secretary.

TN No. MA 92-11

Supersedes

Approval Date 02/17/93

Effective Date 07/01/92

TN No. N/A

HCFA ID: \_\_\_\_\_



Revision: HCFA-PM-92-3  
APRIL 1992

(HSQB)

OMB No.:

State/Territory: South Carolina

- 1919(g) (2) (D) of the Act (m) The State provides for programs to measure and reduce inconsistency in the application of survey results among surveyors. ATTACHMENT 4.40-D describes the State's programs.
- 1919(g) (2) (E) (i) of the Act (n) The State uses a multidisciplinary team of professionals including a registered professional nurse.
- 1919(g) (2) (E) (ii) of the Act (o) The State assures that members of a survey team do not serve (or have not served within the previous two years) as a member of the staff or consultant to the nursing facility or has no personal or familial financial interest in the facility being surveyed.
- 1919(g) (2) (E) (iii) of the Act (p) The State assures that no individual shall serve as a member of any survey team unless the individual has successfully completed a training and test program in survey and certification techniques approved by the Secretary.
- 1919(g) (4) of the Act (q) The State maintains procedures and adequate staff to investigate complaints of violations of requirements by nursing facilities and onsite monitoring. ATTACHMENT 4.40-E describes the State's complaint procedures.
- 1919(g) (5) (A) of the Act (r) The State makes available to the public information respecting surveys and certification of nursing facilities including statements of deficiencies, plans of correction, copies of cost reports, statements of ownership and the information disclosed under Section 1126 of the Act.
- 1919(g) (5) (B) of the Act (s) The State notifies the State long-term care ombudsman of the State's finding of non-compliance with any of the requirements of subsection (b), (c), and (d) or of any adverse actions taken against a nursing facility.
- 1919(g) (5) (C) of the Act (t) If the State finds substandard quality of care in a facility, the State notifies the attending physician of each resident with respect to which such finding is made and the nursing facility administrator licensing board.
- 1919(g) (5) (D) of the Act (u) The State provides the State Medicaid fraud and abuse agency access to all information concerning survey and certification actions.

TN No. MA 92-11  
Supersedes  
TN No. N/A

Approval Date 02/17/93

Effective Date 07/01/92  
HCFA ID: \_\_\_\_\_

Revision: HCFA-PM-92-2 (HSQB)  
MARCH 1992

State/Territory: South Carolina

<u>Citation</u>	4.41 <u>Resident Assessment for Nursing Facilities</u>
Sections 1919(b) (3) and 1919 (e) (5) of the Act	(a) The State specifies the instrument to be used by nursing facilities for conducting a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity as required in §1919(b) (3) (A) of the Act.
1919(e) (5) (A) of the Act	(b) The State is using:  _____ The resident assessment instrument designated by the Health Care Financing Administration (see Transmittal #241 of the <u>State Operations Manual</u> ) [§1919(e) (5) (A); or
1919(e) (5) (B) of the Act	<u>X</u> A resident assessment instrument that the Secretary has approved as being consistent with the minimum data set of core elements, common definitions, and utilization guidelines as specified by the Secretary (See Section 4470 of the <u>State Medicaid Manual</u> for the Secretary's approval criteria) [§1919(e) (5) (B)].

TN No. MA 92-10  
Supersedes  
TN No. N/A

Approval Date 10/20/92

Effective Date 07/01/92

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: SOUTH CAROLINA

Citation  
1902(a)(68) of  
the Act,  
P.L. 109-171  
(section 6032)

4.42 Employee Education About False Claims Recoveries.

- (a) The Medicaid agency meets the requirements regarding establishment of policies and procedures for the education of employees of entities covered by section 1902(a)(68) of the Social Security Act (the Act) regarding false claims recoveries and methodologies for oversight of entities' compliance with these requirements.

(1) Definitions.

(A) An "entity" includes a governmental agency, organization, unit, corporation, partnership, or other business arrangement (including any Medicaid managed care organization, irrespective of the form of business structure or arrangement by which it exists), whether for-profit or not-for-profit, which receives or makes payments, under a State Plan approved under title XIX or under any waiver of such plan, totaling at least \$5,000,000 annually.

If an entity furnishes items or services at more than a single location or under more than one contractual or other payment arrangement, the provisions of section 1902(a)(68) apply if the aggregate payments to that entity meet the \$5,000,000 annual threshold. This applies whether the entity submits claims for payments using one or more provider identification or tax identification numbers.

A governmental component providing Medicaid health care items or services for which Medicaid payments are made would qualify as an "entity" (e.g., a state mental

79y.1

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
health facility or school district providing school-  
based health services). A government agency which  
State/Territory: SOUTH CAROLINA merely administers the Medicaid program, in whole  
or part (e.g., managing the claims processing system  
or determining beneficiary eligibility), is not, for  
these purposes, considered to be an entity.

An entity will have met the \$5,000,000 annual  
threshold as of January 1, 2007, if it received or  
made payments in that amount in Federal fiscal year  
2006. Future determinations regarding an entity's  
responsibility stemming from the requirements of  
section 1902(a)(68) will be made by January 1 of  
each subsequent year, based upon the amount of  
payments an entity either received or made under  
the State Plan during the preceding Federal fiscal  
year.

(B) An "employee" includes any officer or  
employee of the entity.

(C) A "contractor" or "agent" includes any  
contractor, subcontractor, agent, or other person  
which or who, on behalf of the entity, furnishes, or  
otherwise authorizes the furnishing of, Medicaid  
health care items or services, performs billing or  
coding functions, or is involved in the monitoring of  
health care provided by the entity.

(2) The entity must establish and disseminate written  
policies which must also be adopted by its contractors  
or agents. Written policies may be on paper or in  
electronic form, but must be readily available to all  
employees, contractors, or agents. The entity need not  
create an employee handbook if none already exists.

79y.2

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: SOUTH CAROLINA

- (3) An entity shall establish written policies for all employees (including management), and of any contractor or agent of the entity, that include detailed information about the False Claims Act and the other provisions named in section 1902(a)(68)(A). The entity shall include in those written policies detailed information about the entity's policies and procedures for detecting and preventing waste, fraud, and abuse. The entity shall also include in any employee handbook a specific discussion of the laws described in the written policies, the rights of employees to be protected as whistleblowers and a specific discussion of the entity's policies and procedures for detecting and preventing fraud, waste, and abuse.
- (4) The requirements of this law should be incorporated into each State's provider enrollment agreements.
- (5) The State will implement this State Plan amendment on January 1, 2007.
- (b) ATTACHMENT 4.42-A describes, in accordance with section 1902(a)(68) of the Act, the methodology of compliance oversight and the frequency with which the State will re-assess compliance on an ongoing basis.

## STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: South Carolina**4.46 Provider Screening and Enrollment**Citation

1902(a)(77)  
 1902(a)(39)  
 1902(kk);  
 P.L. 111-148 and  
 P.L. 111-152

The State Medicaid agency gives the following assurances:

42 CFR 455  
 Subpart E

## PROVIDER SCREENING

X Assures that the State Medicaid agency complies with the process for screening providers under section 1902(a)(39), 1902(a)(77) and 1902(kk) of the Act.

42 CFR 455.410

## ENROLLMENT AND SCREENING OF PROVIDERS

X Assures enrolled providers will be screened in accordance with 42 CFR 455.400 et seq.

X Assures that the State Medicaid agency requires all ordering or referring physicians or other professionals to be enrolled under the State plan or under a waiver of the Plan as a participating provider.

42 CFR 455.412

## VERIFICATION OF PROVIDER LICENSES

X Assures that the State Medicaid agency has a method for verifying providers licensed by a State and that such providers licenses have not expired or have no current limitations.

42 CFR 455.414

## REVALIDATION OF ENROLLMENT

X Assures that providers will be revalidated regardless of provider type at least every 5 years.

42 CFR 455.416

## TERMINATION OR DENIAL OF ENROLLMENT

X Assures that the State Medicaid agency will comply with section 1902(a)(39) of the Act and with the requirements outlined in 42 CFR 455.416 for all terminations or denials of provider enrollment.

42 CFR 455.420

## REACTIVATION OF PROVIDER ENROLLMENT

X Assures that any reactivation of a provider will include re-screening and payment of application fees as required by 42 CFR 455.460.

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 TN No. SC 12-015

Supersedes

Approval Date 9/25/12Effective Date: 12/01/12TN No. SC 12-010

- 42 CFR 455.422 APPEAL RIGHTS  
 X  Assures that all terminated providers and providers denied enrollment as a result of the requirements of 42 CFR 455.416 will have appeal rights available under procedures established by State law or regulation.
- 42 CFR 455.432 SITE VISITS  
 X  Assures that pre-enrollment and post-enrollment site visits of providers who are in “moderate” or “high” risk categories will occur.
- 42 CFR 455.434 CRIMINAL BACKGROUND CHECKS  
 X  Assures that providers, as a condition of enrollment, will be required to consent to criminal background checks including fingerprints, if required to do so under State law, or by the level of screening based on risk of fraud, waste or abuse for that category of provider.
- 42 CFR 455.436 FEDERAL DATABASE CHECKS  
 X  Assures that the State Medicaid agency will perform Federal database checks on all providers or any person with an ownership or controlling interest or who is an agent or managing employee of the provider.
- 42 CFR 455.440 NATIONAL PROVIDER IDENTIFIER  
 X  Assures that the State Medicaid agency requires the National Provider Identifier of any ordering or referring physician or other professional to be specified on any claim for payment that is based on an order or referral of the physician or other professional.
- 42 CFR 455.450 SCREENING LEVELS FOR MEDICAID PROVIDERS  
 X  Assures that the State Medicaid agency complies with 1902(a)(77) and 1902(kk) of the Act and with the requirements outlined in 42 CFR 455.450 for screening levels based upon the categorical risk level determined for a provider.
- 42 CFR 455.460 APPLICATION FEE  
 X  Assures that the State Medicaid agency complies with the requirements for collection of the application fee set forth in section 1866(j)(2)(C) of the Act and 42 CFR 455.460.
- 42 CFR 455.470 TEMPORARY MORATORIUM ON ENROLLMENT OF NEW PROVIDERS OR SUPPLIERS  
 X  Assures that the State Medicaid agency complies with any temporary moratorium on the enrollment of new providers or provider types imposed by the Secretary under section 1866(j)(7) and 1902(kk)(4) of the Act, subject to any determination by the State and written notice to the Secretary that such a temporary moratorium would not adversely impact beneficiaries’ access to medical assistance.

Revision: HCFA-AT-80-38 (BPP)  
May 22, 1980

State South Carolina

SECTION 5: PERSONNEL ADMINISTRATION

Citation 5.1 Standards of Personnel Administration

42 CFR 432.10(a)

AT-78-90

AT-79-23

AT-80-34

- (a) The Medicaid Agency has established and will maintain methods of personnel administration in conformity with standards prescribed by the U.S. Civil Service Commission in accordance with Section 208 of the Intergovernmental Personnel Act of 1970 and the regulations on Administration of the Standards for a Merit System of Personnel Administration, 5 CFR Part 900, Subpart F, All requirements of 42 CFR 432.10 are met.

The plan is locally administered and State-supervised. The requirements of 42 CFR 432.10 with respect to local agency administration are met.

(b) Affirmative Action Plan

The Medicaid Agency has in effect an affirmative action plan for equal employment opportunity that includes specific action steps and timetables and meets all other requirements of 5 CFR Part 900, Subpart F.

TN No. 77-7

Supersedes

TN No. \_\_\_\_\_

Approval Date 11/23/77

Effective Date 09/30/79



Revision: HCFA-AT-80-38 (BPP)  
May 22, 1980

State \_\_\_\_\_ South Carolina \_\_\_\_\_

5.2 [Reserved]

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TN No. \_\_\_\_\_  
Supersedes \_\_\_\_\_ Approval Date \_\_\_\_\_ Effective Date \_\_\_\_  
TN No. \_\_\_\_\_

Revision: HCFA-AT-80-38 (BPP)  
May 22, 1980

State South Carolina

Citation  
42 CFR Part 432,  
Subpart B  
AT-78-90

5.3 Training Program: Sub professional and  
Volunteer Programs

The Medicaid agency meets the requirements of 42 CFR Part 432, Subpart B, with respect to a training program for agency personnel and the training and use of sub professional staff and volunteers.

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TN No. 78-1  
Supersedes \_\_\_\_\_ Approval Date 4/20/78 Effective Date 4/20/78  
TN No. \_\_\_\_\_

Revision: HCFA-AT-80-38 (BPP)  
May 22, 1980

State South Carolina

SECTION 6: FINANCIAL ADMINISTRATION

Citation  
42 CFR 433.32  
AT-79-29

6.1 Fiscal Policies and Accountability

The Medicaid agency and, where applicable, local agencies administering the plan, maintains an accounting system and supporting fiscal records adequate to assure that claims for Federal funds are in accord with applicable Federal requirements. The requirements of 42 CFR 433.32 are met.

TN No. 76-11  
Supersedes  
TN No. \_\_\_\_\_

Approval Date 08/26/76

Effective Date 6/30/76

Revision: HCFA-AT-81- (BPP)

State South Carolina

Citation  
42 CFR 433.34  
47 FR 17490

6.2 Cost Allocation

There is an approved cost allocation plan on file with the Department in accordance with the requirements contained in 45 CFR Part 95, Subpart E.

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TN No. MA 82-13  
Supersedes  
TN No. 76-11

Approval Date 08/18/82

Effective Date 7/16/82

Revision: HCFA-AT-80-38 (BPP)  
May 22, 1980

State South Carolina

Citation  
42 CFR 433.33  
AT-79-29  
AT-80-34

6.3 State Financial Participation

(a) State funds are used in both assistance and administration.

State funds are used to pay all of the non-Federal share of total expenditures under the plan.

There is local participation.

State

funds are used to pay not less than 40 percent of the non-Federal share of the total expenditures under the plan. There is a method of apportioning Federal and State funds among the political subdivisions of the State on an equalization or other basis which assures that lack of adequate funds from local sources will not result in lowering the amount, duration, scope or quality of care and services or level of administration under the plan in any part of the State.

(b) State and Federal funds are apportioned among the political subdivisions of the State on a basis consistent with equitable treatment of individuals in similar circumstances throughout the State.

TN No. 76-11  
Supersedes \_\_\_\_\_  
TN No. \_\_\_\_\_

Approval Date 08/26/76

Effective Date 6/30/76

Revision: HCFA-PM-91-4 (BPD) OMB. No. 0938-  
AUGUST 1991

State/Territory: South Carolina

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SECTION 7 - GENERAL PROVISIONS

Citation            7.1    Plan Amendments

42 CFR 430.12(c)  
reflect

The plan will be amended whenever necessary to  
new or revised Federal statutes or regulations or  
material change in State law, organization, policy or  
State agency operation.

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TN No. MA 92-07  
Supersedes  
TN No. MA 77-09

Approval Date 06/04/92

Effective Date 1/01/92

HFCA ID: 7982E

Revision: HCFA-PM-91-4 (BPD) OMB. No. 0938-  
AUGUST 1991

State/Territory: South Carolina

Citation                    7.2    Nondiscrimination

45 CFR Parts  
of  
80 and 84

In accordance with title VI of the Civil Rights Act  
1964 (42 U.S.C. 2000d et.seq.), Section 504 of the  
Rehabilitation Act of 1973 (29 U.S.C. 70b), and the  
regulations at 45 CFR Parts 80 and 84, the Medicaid  
agency assures that no individual shall be subject to  
discrimination under this plan on the grounds of  
race, color, national origin, or handicap.

The Medicaid agency has methods of administration to  
assure that each program or activity for which it  
receives Federal financial assistance will be  
operated in accordance with title VI regulations.  
These methods for title VI are described in  
ATTACHMENT 7.2-A.

TN No. MA 92-07  
Supersedes  
TN No. MA 79-05

Approval Date 06/04/92

Effective Date 1/01/92

HFCA ID: 7982E

Revision: HCFA-AT-80-38 (BPP)  
May 22, 1980

State: South Carolina

Citation  
45 CFR 204.1

7.3 State Governor's Review

The Medicaid agency will provide opportunity or the Office of the Governor to review amendments, any new State plan and subsequent amendments, and long-range program planning projections or other periodic reports thereon. Any comments made will be transmitted to the Health Care Financing Administration with such documents.

- Not applicable. The Governor—
  - Does not wish to review any plan material.
  - Wishes to review only the plan material specified in the enclosed document.

I hereby certify that I am authorized to submit this plan on behalf of

THE SOUTH CAROLINA STATE DEPARTMENT OF SOCIAL SERVICES  
(Designated Single State Agency)

Date July 1, 1980

Virgil L. Conrad  
(Signature)

Commissioner  
(Title)

TN No. 77-9  
Supersedes  
TN No. \_\_\_\_\_

Approval Date 02/15/79

Effective Date 01/01/78



Revision: HCFA-PM-91-4 (BPD)  
August 1991

OMB NO. 0938-

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: South Carolina

Citation (s) 7.4 State Governor's Review

42 CFR 430.12 (b) The Medicaid agency will provide opportunity for the office of the Governor to review State plan amendments, long-range program planning projections, and other periodic reports thereon, excluding periodic statistical, budget and fiscal reports. Any comments made will be transmitted to the Centers for Medicare and Medicaid Services with such documents.

- Not applicable. The Governor--
- Does not wish to review any plan material.
- Wishes to review only the plan materials specified in the enclosed document.

I hereby certify that I am authorized to submit these plans on behalf of  
South Carolina Department of Health and Human Services

(Designated Single State Agency)

Date: April 20, 2021



\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
Director  
(Title)

TN No.: SC 21-0009  
Supersedes

TN No.: SC 21-0001

Approval Date: 06/03/21

Effective Date: 04/20/21

**Section 7 – General Provisions**  
**7.4. Medicaid Disaster Relief for the COVID-19 National Emergency**

On March 13, 2020, the President of the United States issued a proclamation that the COVID-19 outbreak in the United States constitutes a national emergency by the authorities vested in him by the Constitution and the laws of the United States, including sections 201 and 301 of the National Emergencies Act (50 U.S.C. 1601 et seq.), and consistent with section 1135 of the Social Security Act (Act). On March 13, 2020, pursuant to section 1135(b) of the Act, the Secretary of the United States Department of Health and Human Services invoked his authority to waive or modify certain requirements of titles XVIII, XIX, and XXI of the Act as a result of the consequences COVID-19 pandemic, to the extent necessary, as determined by the Centers for Medicare & Medicaid Services (CMS), to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in the respective programs and to ensure that health care providers that furnish such items and services in good faith, but are unable to comply with one or more of such requirements as a result of the COVID-19 pandemic, may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse. This authority took effect as of 6PM Eastern Standard Time on March 15, 2020, with a retroactive effective date of March 1, 2020. The emergency period will terminate, and waivers will no longer be available, upon termination of the public health emergency, including any extensions.

The State Medicaid agency (agency) seeks to implement the policies and procedures described below, which are different than the policies and procedures otherwise applied under the Medicaid state plan, during the period of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof), or for any shorter period described below:

<i>Describe shorter period here.</i>
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NOTE: States may not elect a period longer than the Presidential or Secretarial emergency declaration (or any renewal thereof). States may not propose changes on this template that restrict or limit payment, services, or eligibility, or otherwise burden beneficiaries and providers.

**Request for Waivers under Section 1135**

  X   The agency seeks the following under section 1135(b)(1)(C) and/or section 1135(b)(5) of the Act:

- a.   X   SPA submission requirements – the agency requests modification of the requirement to submit the SPA by March 31, 2020, to obtain a SPA effective date during the first calendar quarter of 2020, pursuant to 42 CFR 430.20.
- b.        Public notice requirements – the agency requests waiver of public notice requirements that would otherwise be applicable to this SPA submission. These requirements may include those specified in 42 CFR 440.386 (Alternative Benefit Plans), 42 CFR 447.57(c) (premiums and cost sharing), and 42 CFR 447.205 (public notice of changes in statewide methods and standards for setting payment rates).

- c.        Tribal consultation requirements – the agency requests modification of tribal consultation timelines specified in [insert name of state] Medicaid state plan, as described below:

*Please describe the modifications to the timeline.*

**Section A – Eligibility**

- 1.   X   The agency furnishes medical assistance to the following optional groups of individuals described in section 1902(a)(10)(A)(ii) or 1902(a)(10)(c) of the Act. This may include the new optional group described at section 1902(a)(10)(A)(ii)(XXIII) and 1902(ss) of the Act providing coverage for uninsured individuals.

*Include name of the optional eligibility group and applicable income and resource standard.*

*The state elects to cover all uninsured individuals as defined under 1902(ss) of the Act pursuant to Section 1902(a)(10)(A)(ii)(XXIII) of the Act.*

*Name of Eligibility Group: COVID-19 Testing No income or resource standards*

- 2.        The agency furnishes medical assistance to the following populations of individuals described in section 1902(a)(10)(A)(ii)(XX) of the Act and 42 CFR 435.218:

- a.        All individuals who are described in section 1905(a)(10)(A)(ii)(XX)

Income standard: \_\_\_\_\_

-or-

- b.        Individuals described in the following categorical populations in section 1905(a) of the Act:

Income standard: \_\_\_\_\_

- 3.        The agency applies less restrictive financial methodologies to individuals excepted from financial methodologies based on modified adjusted gross income (MAGI) as follows.

Less restrictive income methodologies:

Less restrictive resource methodologies:

4. \_\_\_\_\_ The agency considers individuals who are evacuated from the state, who leave the state for medical reasons related to the disaster or public health emergency, or who are otherwise absent from the state due to the disaster or public health emergency and who intend to return to the state, to continue to be residents of the state under 42 CFR 435.403(j)(3).
  
5. \_\_\_\_\_ The agency provides Medicaid coverage to the following individuals living in the state, who are non-residents:

6. \_\_\_\_\_ The agency provides for an extension of the reasonable opportunity period for non-citizens declaring to be in a satisfactory immigration status, if the non-citizen is making a good faith effort to resolve any inconsistencies or obtain any necessary documentation, or the agency is unable to complete the verification process within the 90-day reasonable opportunity period due to the disaster or public health emergency.

**Section B – Enrollment**

1. \_\_\_\_\_ The agency elects to allow hospitals to make presumptive eligibility determinations for the following additional state plan populations, or for populations in an approved section 1115 demonstration, in accordance with section 1902(a)(47)(B) of the Act and 42 CFR 435.1110, provided that the agency has determined that the hospital is capable of making such determinations.

*Please describe the applicable eligibility groups/populations and any changes to reasonable limitations performance standards or other factors.*

2. \_\_\_\_\_ The agency designates itself as a qualified entity for purposes of making presumptive eligibility determinations described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L.

*Please describe any limitations related to the populations included or the number of allowable PE periods.*

3. \_\_\_\_\_ The agency designates the following entities as qualified entities for purposes of making presumptive eligibility determinations or adds additional populations as described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L. Indicate if any designated entities are permitted to make presumptive eligibility determinations only for specified populations.

*Please describe the designated entities or additional populations and any limitations related to the specified populations or number of allowable PE periods.*

4. \_\_\_\_\_ The agency adopts a total of \_\_\_\_\_ months (not to exceed 12 months) continuous eligibility for children under age enter age \_\_\_\_\_ (not to exceed age 19) regardless of changes in circumstances in accordance with section 1902(e)(12) of the Act and 42 CFR 435.926.
5. \_\_\_\_\_ The agency conducts redeterminations of eligibility for individuals excepted from MAGI-based financial methodologies under 42 CFR 435.603(j) once every \_\_\_\_\_ months (not to exceed 12 months) in accordance with 42 CFR 435.916(b).
6. \_\_\_\_\_ The agency uses the following simplified application(s) to support enrollment in affected areas or for affected individuals (a copy of the simplified application(s) has been submitted to CMS).
- a. \_\_\_\_\_ The agency uses a simplified paper application.
  - b. \_\_\_\_\_ The agency uses a simplified online application.
  - c. \_\_\_\_\_ The simplified paper or online application is made available for use in call-centers or other telephone applications in affected areas.

### **Section C – Premiums and Cost Sharing**

1. \_\_\_\_\_ The agency suspends deductibles, copayments, coinsurance, and other cost sharing charges as follows:

*Please describe whether the state suspends all cost sharing or suspends only specified deductibles, copayments, coinsurance, or other cost sharing charges for specified items and services or for specified eligibility groups consistent with 42 CFR 447.52(d) or for specified income levels consistent with 42 CFR 447.52(g).*

2. \_\_\_\_\_ The agency suspends enrollment fees, premiums and similar charges for:
- a. \_\_\_\_\_ All beneficiaries
  - b. \_\_\_\_\_ The following eligibility groups or categorical populations:

*Please list the applicable eligibility groups or populations.*

3. \_\_\_\_\_ The agency allows waiver of payment of the enrollment fee, premiums and similar charges for undue hardship.

*Please specify the standard(s) and/or criteria that the state will use to determine undue hardship.*

**Section D – Benefits**

*Benefits:*

1. \_\_\_\_\_ The agency adds the following optional benefits in its state plan (include service descriptions, provider qualifications, and limitations on amount, duration or scope of the benefit):

2. \_\_\_\_\_ The agency makes the following adjustments to benefits currently covered in the state plan:

3. \_\_\_\_\_ The agency assures that newly added benefits or adjustments to benefits comply with all applicable statutory requirements, including the statewideness requirements found at 1902(a)(1), comparability requirements found at 1902(a)(10)(B), and free choice of provider requirements found at 1902(a)(23).

4. \_\_\_\_\_ Application to Alternative Benefit Plans (ABP). The state adheres to all ABP provisions in 42 CFR Part 440, Subpart C. This section only applies to states that have an approved ABP(s).

- a. \_\_\_\_\_ The agency assures that these newly added and/or adjusted benefits will be made available to individuals receiving services under ABPs.

- b. \_\_\_\_\_ Individuals receiving services under ABPs will not receive these newly added and/or adjusted benefits, or will only receive the following subset:

*Please describe.*

*Telehealth:*

- 5. \_\_\_\_\_ The agency utilizes telehealth in the following manner, which may be different than outlined in the state’s approved state plan:

*Please describe.*

*Drug Benefit:*

- 6. \_\_\_\_\_ The agency makes the following adjustments to the day supply or quantity limit for covered outpatient drugs. The agency should only make this modification if its current state plan pages have limits on the amount of medication dispensed.

*Please describe the change in days or quantities that are allowed for the emergency period and for which drugs.*

- 7. \_\_\_\_\_ Prior authorization for medications is expanded by automatic renewal without clinical review, or time/quantity extensions.

- 8. \_\_\_\_\_ The agency makes the following payment adjustment to the professional dispensing fee when additional costs are incurred by the providers for delivery. States will need to supply documentation to justify the additional fees.

*Please describe the manner in which professional dispensing fees are adjusted.*

- 9. \_\_\_\_\_ The agency makes exceptions to their published Preferred Drug List if drug shortages occur. This would include options for covering a brand name drug product that is a multi-source drug if a generic drug option is not available.

**Section E – Payments**

*Optional benefits described in Section D:*

- 1. \_\_\_\_\_ Newly added benefits described in Section D are paid using the following methodology:

- a. \_\_\_\_\_ Published fee schedules –

Effective date (enter date of change): \_\_\_\_\_

Location (list published location): \_\_\_\_\_

b. \_\_\_\_\_ Other:

*Describe methodology here.*

*Increases to state plan payment methodologies:*

2. \_\_\_\_\_ The agency increases payment rates for the following services:

*Please list all that apply.*

a. \_\_\_\_\_ Payment increases are targeted based on the following criteria:

*Please describe criteria.*

b. Payments are increased through:

i. \_\_\_\_\_ A supplemental payment or add-on within applicable upper payment limits:

*Please describe.*

ii. \_\_\_\_\_ An increase to rates as described below.

Rates are increased:

\_\_\_\_\_ Uniformly by the following percentage: \_\_\_\_\_

\_\_\_\_\_ Through a modification to published fee schedules –

Effective date (enter date of change): \_\_\_\_\_

Location (list published location): \_\_\_\_\_

\_\_\_\_\_ Up to the Medicare payments for equivalent services.

\_\_\_\_\_ By the following factors:



*Please describe.*

*Payment for services delivered via telehealth:*

- 3.  For the duration of the emergency, the state authorizes payments for telehealth services that:
  - a.  Are not otherwise paid under the Medicaid state plan;
  - b.  Differ from payments for the same services when provided face to face;
  - c.  Differ from current state plan provisions governing reimbursement for telehealth;

*Describe telehealth payment variation.*

- d.  Include payment for ancillary costs associated with the delivery of covered services via telehealth, (if applicable), as follows:
  - i.  Ancillary cost associated with the originating site for telehealth is incorporated into fee-for-service rates.
  - ii.  Ancillary cost associated with the originating site for telehealth is separately reimbursed as an administrative cost by the state when a Medicaid service is delivered.

*Other:*

- 4.  Other payment changes:

*Please describe.*

**Section F – Post-Eligibility Treatment of Income**

- 1.  The state elects to modify the basic personal needs allowance for institutionalized individuals. The basic personal needs allowance is equal to one of the following amounts:
  - a.  The individual’s total income
  - b.  300 percent of the SSI federal benefit rate
  - c.  Other reasonable amount: \_\_\_\_\_
- 2.  The state elects a new variance to the basic personal needs allowance. (Note: Election

of this option is not dependent on a state electing the option described the option in F.1. above.)

The state protects amounts exceeding the basic personal needs allowance for individuals who have the following greater personal needs:

*Please describe the group or groups of individuals with greater needs and the amount(s) protected for each group or groups.*

**Section G – Other Policies and Procedures Differing from Approved Medicaid State Plan /Additional Information**

**PRA Disclosure Statement**

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148 (Expires 03/31/2021). The time required to complete this information collection is estimated to average 1 to 2 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. Your response is required to receive a waiver under Section 1135 of the Social Security Act. All responses are public and will be made available on the CMS web site. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. \*\*\*CMS Disclosure\*\*\* Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact the Centers for Medicaid & CHIP Services at 410-786-3870.

**Section 7 – General Provisions****7.4. Medicaid Disaster Relief for the COVID-19 National Emergency**

On March 13, 2020, the President of the United States issued a proclamation that the COVID-19 outbreak in the United States constitutes a national emergency by the authorities vested in him by the Constitution and the laws of the United States, including sections 201 and 301 of the National Emergencies Act (50 U.S.C. 1601 et seq.), and consistent with section 1135 of the Social Security Act (Act). On March 13, 2020, pursuant to section 1135(b) of the Act, the Secretary of the United States Department of Health and Human Services invoked his authority to waive or modify certain requirements of titles XVIII, XIX, and XXI of the Act as a result of the consequences COVID-19 pandemic, to the extent necessary, as determined by the Centers for Medicare & Medicaid Services (CMS), to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in the respective programs and to ensure that health care providers that furnish such items and services in good faith, but are unable to comply with one or more of such requirements as a result of the COVID-19 pandemic, may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse. This authority took effect as of 6PM Eastern Standard Time on March 15, 2020, with a retroactive effective date of March 1, 2020. The emergency period will terminate, and waivers will no longer be available, upon termination of the public health emergency, including any extensions.

The State Medicaid agency (agency) seeks to implement the policies and procedures described below, which are different than the policies and procedures otherwise applied under the Medicaid state plan, during the period of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof), or for any shorter period described below:

<i>Describe shorter period here.</i>
--------------------------------------

NOTE: States may not elect a period longer than the Presidential or Secretarial emergency declaration (or any renewal thereof). States may not propose changes on this template that restrict or limit payment, services, or eligibility, or otherwise burden beneficiaries and providers.

**Request for Waivers under Section 1135**

The agency seeks the following under section 1135(b)(1)(C) and/or section 1135(b)(5) of the Act:

- a.  SPA submission requirements – the agency requests modification of the requirement to submit the SPA by March 31, 2020, to obtain a SPA effective date during the first calendar quarter of 2020, pursuant to 42 CFR 430.20.
- b.  Public notice requirements – the agency requests waiver of public notice requirements that would otherwise be applicable to this SPA submission. These requirements may include those specified in 42 CFR 440.386 (Alternative Benefit Plans), 42 CFR 447.57(c) (premiums and cost sharing), and 42 CFR 447.205 (public notice of changes in statewide methods and standards for setting payment rates).

- c. \_\_\_\_\_ Tribal consultation requirements – the agency requests modification of tribal consultation timelines specified in [insert name of state] Medicaid state plan, as described below:

*Please describe the modifications to the timeline.*

**Section A – Eligibility**

- 1. \_\_\_\_\_ The agency furnishes medical assistance to the following optional groups of individuals described in section 1902(a)(10)(A)(ii) or 1902(a)(10)(c) of the Act. This may include the new optional group described at section 1902(a)(10)(A)(ii)(XXIII) and 1902(ss) of the Act providing coverage for uninsured individuals.

*Include name of the optional eligibility group and applicable income and resource standard.*

- 2. \_\_\_\_\_ The agency furnishes medical assistance to the following populations of individuals described in section 1902(a)(10)(A)(ii)(XX) of the Act and 42 CFR 435.218:

- a. \_\_\_\_\_ All individuals who are described in section 1905(a)(10)(A)(ii)(XX)

Income standard: \_\_\_\_\_

-or-

- b. \_\_\_\_\_ Individuals described in the following categorical populations in section 1905(a) of the Act:

Income standard: \_\_\_\_\_

- 3. \_\_\_\_\_ The agency applies less restrictive financial methodologies to individuals excepted from financial methodologies based on modified adjusted gross income (MAGI) as follows.

Less restrictive income methodologies:

Less restrictive resource methodologies:

4. \_\_\_\_\_ The agency considers individuals who are evacuated from the state, who leave the state for medical reasons related to the disaster or public health emergency, or who are otherwise absent from the state due to the disaster or public health emergency and who intend to return to the state, to continue to be residents of the state under 42 CFR 435.403(j)(3).

5. \_\_\_\_\_ The agency provides Medicaid coverage to the following individuals living in the state, who are non-residents:

6. \_\_\_\_\_ The agency provides for an extension of the reasonable opportunity period for non-citizens declaring to be in a satisfactory immigration status, if the non-citizen is making a good faith effort to resolve any inconsistencies or obtain any necessary documentation, or the agency is unable to complete the verification process within the 90-day reasonable opportunity period due to the disaster or public health emergency.

**Section B – Enrollment**

1. \_\_\_\_\_ The agency elects to allow hospitals to make presumptive eligibility determinations for the following additional state plan populations, or for populations in an approved section 1115 demonstration, in accordance with section 1902(a)(47)(B) of the Act and 42 CFR 435.1110, provided that the agency has determined that the hospital is capable of making such determinations.

*Please describe the applicable eligibility groups/populations and any changes to reasonable limitations, performance standards or other factors.*

2. \_\_\_\_\_ The agency designates itself as a qualified entity for purposes of making presumptive eligibility determinations described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L.

*Please describe any limitations related to the populations included or the number of allowable PE periods.*

3. \_\_\_\_ The agency designates the following entities as qualified entities for purposes of making presumptive eligibility determinations or adds additional populations as described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L. Indicate if any designated entities are permitted to make presumptive eligibility determinations only for specified populations.

*Please describe the designated entities or additional populations and any limitations related to the specified populations or number of allowable PE periods.*

4. \_\_\_\_ The agency adopts a total of \_\_\_\_ months (not to exceed 12 months) continuous eligibility for children under age enter age \_\_\_\_ (not to exceed age 19) regardless of changes in circumstances in accordance with section 1902(e)(12) of the Act and 42 CFR 435.926.
5. \_\_\_\_ The agency conducts redeterminations of eligibility for individuals excepted from MAGI-based financial methodologies under 42 CFR 435.603(j) once every \_\_\_\_ months (not to exceed 12 months) in accordance with 42 CFR 435.916(b).
6. \_\_\_\_ The agency uses the following simplified application(s) to support enrollment in affected areas or for affected individuals (a copy of the simplified application(s) has been submitted to CMS).
- a. \_\_\_\_ The agency uses a simplified paper application.
- b. \_\_\_\_ The agency uses a simplified online application.
- c. \_\_\_\_ The simplified paper or online application is made available for use in call-centers or other telephone applications in affected areas.

### Section C – Premiums and Cost Sharing

1. X The agency suspends deductibles, copayments, coinsurance, and other cost sharing charges as follows:

Effective for dates of service on or after March 18, 2020, South Carolina Medicaid waives all Medicaid co-payments for all evaluation and management (E/M) codes.

2. \_\_\_\_ The agency suspends enrollment fees, premiums and similar charges for:
- a. \_\_\_\_ All beneficiaries
- b. \_\_\_\_ The following eligibility groups or categorical populations:

*Please list the applicable eligibility groups or populations.*

- 3.  The agency allows waiver of payment of the enrollment fee, premiums and similar charges for undue hardship.

*Please specify the standard(s) and/or criteria that the state will use to determine undue hardship.*

**Section D – Benefits**

*Benefits:*

- 1.  The agency adds the following optional benefits in its state plan (include service descriptions, provider qualifications, and limitations on amount, duration or scope of the benefit):

- 2.  The agency makes the following adjustments to benefits currently covered in the state plan:

Effective for dates of service on or after March 18, 2020, South Carolina Medicaid will suspend the annual limits for RHCs, FQHCs, and Physician services. The provision of care rendered and services billed to Medicaid must meet standard requirements for medical necessity.

- 3.  The agency assures that newly added benefits or adjustments to benefits comply with all applicable statutory requirements, including the statewideness requirements found at 1902(a)(1), comparability requirements found at 1902(a)(10)(B), and free choice of provider requirements found at 1902(a)(23).

- 4.  Application to Alternative Benefit Plans (ABP). The state adheres to all ABP provisions in 42 CFR Part 440, Subpart C. This section only applies to states that have an approved ABP(s).

- a.  The agency assures that these newly added and/or adjusted benefits will be made available to individuals receiving services under ABPs.
- b.  Individuals receiving services under ABPs will not receive these newly added and/or adjusted benefits, or will only receive the following subset:

*Please describe.*

*Telehealth:*

- 5.  The agency utilizes telehealth in the following manner, which may be different than outlined in the state’s approved state plan:

*Please describe.*

*Drug Benefit:*

- 6.  The agency makes the following adjustments to the day supply or quantity limit for covered outpatient drugs. The agency should only make this modification if its current state plan pages have limits on the amount of medication dispensed.

Effective for dates of service on or after March 18, 2020, pharmacies providing medications for fee-for-service beneficiaries may suspend early refill denials, bypassing this requirement , as allowed by law, using an Emergency Preparedness code in the Prior Authorizations Type Code field.

- 7.  Prior authorization for medications is expanded by automatic renewal without clinical review, or time/quantity extensions.
- 8.  The agency makes the following payment adjustment to the professional dispensing fee when additional costs are incurred by the providers for delivery. States will need to supply documentation to justify the additional fees.

*Please describe the manner in which professional dispensing fees are adjusted.*

- 9.  The agency makes exceptions to their published Preferred Drug List if drug shortages occur. This would include options for covering a brand name drug product that is a multi-source drug if a generic drug option is not available.

**Section E – Payments**

*Optional benefits described in Section D:*

- 1.  Newly added benefits described in Section D are paid using the following methodology:
  - a.  Published fee schedules –

Effective date (enter date of change): \_\_\_\_\_

Location (list published location): \_\_\_\_\_



b.  Other:

*Describe methodology here.*

*Increases to state plan payment methodologies:*

2.  The agency increases payment rates for the following services:

*Please list all that apply.*

a.  Payment increases are targeted based on the following criteria:

*Please describe criteria.*

b. Payments are increased through:

i.  A supplemental payment or add-on within applicable upper payment limits:

*Please describe.*

ii.  An increase to rates as described below.

Rates are increased:

Uniformly by the following percentage: \_\_\_\_\_

Through a modification to published fee schedules –

Effective date (enter date of change): \_\_\_\_\_

Location (list published location): \_\_\_\_\_

Up to the Medicare payments for equivalent services.

By the following factors:

*Please describe.*

*Payment for services delivered via telehealth:*

3. \_\_\_\_ For the duration of the emergency, the state authorizes payments for telehealth services that:
- a. \_\_\_\_ Are not otherwise paid under the Medicaid state plan;
  - b. \_\_\_\_ Differ from payments for the same services when provided face to face;
  - c. \_\_\_\_ Differ from current state plan provisions governing reimbursement for telehealth;

*Describe telehealth payment variation.*

- d. \_\_\_\_ Include payment for ancillary costs associated with the delivery of covered services via telehealth, (if applicable), as follows:
  - i. \_\_\_\_ Ancillary cost associated with the originating site for telehealth is incorporated into fee-for-service rates.
  - ii. \_\_\_\_ Ancillary cost associated with the originating site for telehealth is separately reimbursed as an administrative cost by the state when a Medicaid service is delivered.

*Other:*

4. \_\_\_\_ Other payment changes:

*Please describe.*

**Section F – Post-Eligibility Treatment of Income**

1. \_\_\_\_ The state elects to modify the basic personal needs allowance for institutionalized individuals. The basic personal needs allowance is equal to one of the following amounts:
- a. \_\_\_\_ The individual’s total income
  - b. \_\_\_\_ 300 percent of the SSI federal benefit rate
  - c. \_\_\_\_ Other reasonable amount: \_\_\_\_\_
2. \_\_\_\_ The state elects a new variance to the basic personal needs allowance. (Note: Election

of this option is not dependent on a state electing the option described the option in F.1. above.)

The state protects amounts exceeding the basic personal needs allowance for individuals who have the following greater personal needs:

*Please describe the group or groups of individuals with greater needs and the amount(s) protected for each group or groups.*

**Section G – Other Policies and Procedures Differing from Approved Medicaid State Plan /Additional Information**

**PRA Disclosure Statement**

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148 (Expires 03/31/2021). The time required to complete this information collection is estimated to average 1 to 2 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. Your response is required to receive a waiver under Section 1135 of the Social Security Act. All responses are public and will be made available on the CMS web site. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. \*\*\*CMS Disclosure\*\*\* Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact the Centers for Medicaid & CHIP Services at 410-786-3870.

**Section 7 – General Provisions****7.4. Medicaid Disaster Relief for the COVID-19 National Emergency**

On March 13, 2020, the President of the United States issued a proclamation that the COVID-19 outbreak in the United States constitutes a national emergency by the authorities vested in him by the Constitution and the laws of the United States, including sections 201 and 301 of the National Emergencies Act (50 U.S.C. 1601 et seq.), and consistent with section 1135 of the Social Security Act (Act). On March 13, 2020, pursuant to section 1135(b) of the Act, the Secretary of the United States Department of Health and Human Services invoked his authority to waive or modify certain requirements of titles XVIII, XIX, and XXI of the Act as a result of the consequences COVID-19 pandemic, to the extent necessary, as determined by the Centers for Medicare & Medicaid Services (CMS), to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in the respective programs and to ensure that health care providers that furnish such items and services in good faith, but are unable to comply with one or more of such requirements as a result of the COVID-19 pandemic, may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse. This authority took effect as of 6PM Eastern Standard Time on March 15, 2020, with a retroactive effective date of March 1, 2020. The emergency period will terminate, and waivers will no longer be available, upon termination of the public health emergency, including any extensions.

The State Medicaid agency (agency) seeks to implement the policies and procedures described below, which are different than the policies and procedures otherwise applied under the Medicaid state plan, during the period of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof), or for any shorter period described below:

<i>Describe shorter period here.</i>
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NOTE: States may not elect a period longer than the Presidential or Secretarial emergency declaration (or any renewal thereof). States may not propose changes on this template that restrict or limit payment, services, or eligibility, or otherwise burden beneficiaries and providers.

**Request for Waivers under Section 1135**

The agency seeks the following under section 1135(b)(1)(C) and/or section 1135(b)(5) of the Act:

- a.  SPA submission requirements – the agency requests modification of the requirement to submit the SPA by March 31, 2020, to obtain a SPA effective date during the first calendar quarter of 2020, pursuant to 42 CFR 430.20.
- b.  Public notice requirements – the agency requests waiver of public notice requirements that would otherwise be applicable to this SPA submission. These requirements may include those specified in 42 CFR 440.386 (Alternative Benefit Plans), 42 CFR 447.57(c) (premiums and cost sharing), and 42 CFR 447.205 (public notice of changes in statewide methods and standards for setting payment rates).

- c.  Tribal consultation requirements – the agency requests modification of tribal consultation timelines specified in [insert name of state] Medicaid state plan, as described below:

*Please describe the modifications to the timeline.*  
 Retroactive effective date back to the beginning of the PHE on 3/18/2020

**Section A – Eligibility**

- 1.  The agency furnishes medical assistance to the following optional groups of individuals described in section 1902(a)(10)(A)(ii) or 1902(a)(10)(c) of the Act. This may include the new optional group described at section 1902(a)(10)(A)(ii)(XXIII) and 1902(ss) of the Act providing coverage for uninsured individuals.

*Include name of the optional eligibility group and applicable income and resource standard.*

- 2.  The agency furnishes medical assistance to the following populations of individuals described in section 1902(a)(10)(A)(ii)(XX) of the Act and 42 CFR 435.218:

- a.  All individuals who are described in section 1905(a)(10)(A)(ii)(XX)

Income standard: \_\_\_\_\_

-or-

- b.  Individuals described in the following categorical populations in section 1905(a) of the Act:

Income standard: \_\_\_\_\_

- 3.  The agency applies less restrictive financial methodologies to individuals excepted from financial methodologies based on modified adjusted gross income (MAGI) as follows.

Less restrictive income methodologies:

Less restrictive resource methodologies:

- 4. \_\_\_\_\_ The agency considers individuals who are evacuated from the state, who leave the state for medical reasons related to the disaster or public health emergency, or who are otherwise absent from the state due to the disaster or public health emergency and who intend to return to the state, to continue to be residents of the state under 42 CFR 435.403(j)(3).
  
- 5. \_\_\_\_\_ The agency provides Medicaid coverage to the following individuals living in the state, who are non-residents:

- 6. \_\_\_\_\_ The agency provides for an extension of the reasonable opportunity period for non-citizens declaring to be in a satisfactory immigration status, if the non-citizen is making a good faith effort to resolve any inconsistencies or obtain any necessary documentation, or the agency is unable to complete the verification process within the 90-day reasonable opportunity period due to the disaster or public health emergency.

**Section B – Enrollment**

- 1. \_\_\_\_\_ The agency elects to allow hospitals to make presumptive eligibility determinations for the following additional state plan populations, or for populations in an approved section 1115 demonstration, in accordance with section 1902(a)(47)(B) of the Act and 42 CFR 435.1110, provided that the agency has determined that the hospital is capable of making such determinations.

*Please describe the applicable eligibility groups/populations and any changes to reasonable limitations, performance standards or other factors.*

- 2. \_\_\_\_\_ The agency designates itself as a qualified entity for purposes of making presumptive eligibility determinations described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L.

*Please describe any limitations related to the populations included or the number of allowable PE periods.*

3. \_\_\_\_\_ The agency designates the following entities as qualified entities for purposes of making presumptive eligibility determinations or adds additional populations as described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L. Indicate if any designated entities are permitted to make presumptive eligibility determinations only for specified populations.

*Please describe the designated entities or additional populations and any limitations related to the specified populations or number of allowable PE periods.*

4. \_\_\_\_\_ The agency adopts a total of \_\_\_\_\_ months (not to exceed 12 months) continuous eligibility for children under age enter age \_\_\_\_\_ (not to exceed age 19) regardless of changes in circumstances in accordance with section 1902(e)(12) of the Act and 42 CFR 435.926.
5. \_\_\_\_\_ The agency conducts redeterminations of eligibility for individuals excepted from MAGI-based financial methodologies under 42 CFR 435.603(j) once every \_\_\_\_\_ months (not to exceed 12 months) in accordance with 42 CFR 435.916(b).
6. \_\_\_\_\_ The agency uses the following simplified application(s) to support enrollment in affected areas or for affected individuals (a copy of the simplified application(s) has been submitted to CMS).
- \_\_\_\_\_ The agency uses a simplified paper application.
  - \_\_\_\_\_ The agency uses a simplified online application.
  - \_\_\_\_\_ The simplified paper or online application is made available for use in call-centers or other telephone applications in affected areas.

### Section C – Premiums and Cost Sharing

1. \_\_\_\_\_ The agency suspends deductibles, copayments, coinsurance, and other cost sharing charges as follows:

*Please describe whether the state suspends all cost sharing or suspends only specified deductibles, copayments, coinsurance, or other cost sharing charges for specified items and services or for specified eligibility groups consistent with 42 CFR 447.52(d) or for specified income levels consistent with 42 CFR 447.52(g).*

2. \_\_\_\_\_ The agency suspends enrollment fees, premiums and similar charges for:
- \_\_\_\_\_ All beneficiaries
  - \_\_\_\_\_ The following eligibility groups or categorical populations:

*Please list the applicable eligibility groups or populations.*

3. \_\_\_\_\_ The agency allows waiver of payment of the enrollment fee, premiums and similar charges for undue hardship.

*Please specify the standard(s) and/or criteria that the state will use to determine undue hardship.*

**Section D – Benefits**

*Benefits:*

1. \_\_\_\_\_ The agency adds the following optional benefits in its state plan (include service descriptions, provider qualifications, and limitations on amount, duration or scope of the benefit):

2. \_\_\_\_\_ The agency makes the following adjustments to benefits currently covered in the state plan:

3. \_\_\_\_\_ The agency assures that newly added benefits or adjustments to benefits comply with all applicable statutory requirements, including the statewide requirements found at 1902(a)(1), comparability requirements found at 1902(a)(10)(B), and free choice of provider requirements found at 1902(a)(23).

4. \_\_\_\_\_ Application to Alternative Benefit Plans (ABP). The state adheres to all ABP provisions in 42 CFR Part 440, Subpart C. This section only applies to states that have an approved ABP(s).

- a. \_\_\_\_\_ The agency assures that these newly added and/or adjusted benefits will be made available to individuals receiving services under ABPs.

- b. \_\_\_\_\_ Individuals receiving services under ABPs will not receive these newly added and/or adjusted benefits, or will only receive the following subset:

*Please describe.*



*Telehealth:*

- 5.  The agency utilizes telehealth in the following manner, which may be different than outlined in the state’s approved state plan:

*Please describe.*

*Drug Benefit:*

- 6.  The agency makes the following adjustments to the day supply or quantity limit for covered outpatient drugs. The agency should only make this modification if its current state plan pages have limits on the amount of medication dispensed.

The State is requesting to waive any signature requirements for the dispensing of drugs during the Public Health Emergency

- 7.  Prior authorization for medications is expanded by automatic renewal without clinical review, or time/quantity extensions.

- 8.  The agency makes the following payment adjustment to the professional dispensing fee when additional costs are incurred by the providers for delivery. States will need to supply documentation to justify the additional fees.

*Please describe the manner in which professional dispensing fees are adjusted.*

- 9.  The agency makes exceptions to their published Preferred Drug List if drug shortages occur. This would include options for covering a brand name drug product that is a multi-source drug if a generic drug option is not available.

**Section E – Payments**

*Optional benefits described in Section D:*

- 1.  Newly added benefits described in Section D are paid using the following methodology:

- a.  Published fee schedules –

Effective date (enter date of change): \_\_\_\_\_

Location (list published location): \_\_\_\_\_

- b.  Other:

*Describe methodology here.*

*Increases to state plan payment methodologies:*

2. \_\_\_\_\_ The agency increases payment rates for the following services:

*Please list all that apply.*

a. \_\_\_\_\_ Payment increases are targeted based on the following criteria:

*Please describe criteria.*

b. Payments are increased through:

i. \_\_\_\_\_ A supplemental payment or add-on within applicable upper payment limits:

*Please describe.*

ii. \_\_\_\_\_ An increase to rates as described below.

Rates are increased:

\_\_\_\_\_ Uniformly by the following percentage: \_\_\_\_\_

\_\_\_\_\_ Through a modification to published fee schedules –

Effective date (enter date of change): \_\_\_\_\_

Location (list published location): \_\_\_\_\_

\_\_\_\_\_ Up to the Medicare payments for equivalent services.

\_\_\_\_\_ By the following factors:

*Please describe.*

*Payment for services delivered via telehealth:*

- 3.  For the duration of the emergency, the state authorizes payments for telehealth services that:
  - a.  Are not otherwise paid under the Medicaid state plan;
  - b.  Differ from payments for the same services when provided face to face;
  - c.  Differ from current state plan provisions governing reimbursement for telehealth;

*Describe telehealth payment variation.*

- d.  Include payment for ancillary costs associated with the delivery of covered services via telehealth, (if applicable), as follows:
  - i.  Ancillary cost associated with the originating site for telehealth is incorporated into fee-for-service rates.
  - ii.  Ancillary cost associated with the originating site for telehealth is separately reimbursed as an administrative cost by the state when a Medicaid service is delivered.

*Other:*

- 4.  Other payment changes:

*Please describe.*

**Section F – Post-Eligibility Treatment of Income**

- 1.  The state elects to modify the basic personal needs allowance for institutionalized individuals. The basic personal needs allowance is equal to one of the following amounts:
  - a.  The individual’s total income
  - b.  300 percent of the SSI federal benefit rate
  - c.  Other reasonable amount: \_\_\_\_\_
- 2.  The state elects a new variance to the basic personal needs allowance. (Note: Election of this option is not dependent on a state electing the option described the option in F.1. above.)

The state protects amounts exceeding the basic personal needs allowance for individuals who have the following greater personal needs:

*Please describe the group or groups of individuals with greater needs and the amount(s) protected for each group or groups.*

**Section G – Other Policies and Procedures Differing from Approved Medicaid State Plan /Additional Information**

**PRA Disclosure Statement**

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