SECTION 2
POLICIES AND PROCEDURES

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PROGRAM DESCRIPTION

OVERVIEW

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

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

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

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If the applicant meets the financial eligibility requirements to participate in the OSS program (see "Eligibility Criteria" later in this section), the eligibility office notifies the DHHS Regional Office (DRO) that the applicant has been determined financially eligible and is requesting an OSS slot.

A monthly payment is made on behalf of the OSS beneficiary to the facility where the beneficiary resides to cover the difference between the beneficiary's monthly countable income and the OSS net income limit. The OSS payment is considered payment in full, and any differences

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in the payment amount due to rounding in the system cannot be charged to the resident or the responsible party.

Waiting List Policy

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

The DHHS central office maintains a statewide waiting list, and applicants are placed on the list chronologically by the date the DRO receives the referral (OSS Slot Reservation Form, DHHS Form 3264ME — see Section 4 for an example). Available slots assigned on a first-come, first-served basis provide for a one-for-one replacement of each resident terminated from the OSS program. Priority is given to Adult Protective Service (APS) clients as appropriate. However, APS clients must still be determined eligible and a slot approved prior to admission. OSS payment does not begin until the date the slot is approved.

Resident Admission to a Facility

When an OSS slot becomes available, an applicant receives a Communication Form (DHHS CRCF-02 — see Section 4) and takes it to a participating CRCF. Once the applicant is admitted, the CRCF completes Section II (the shaded area) of the Communication Form and returns it to the DRO. A delay in returning the DHHS CRCF-02 or the provision of incorrect or incomplete information may result in a delay of the OSS payment to the facility. This slot notification is only valid for a period of 30 days from the date issued and must be returned to the DRO within the 30-day period.

Section III of the original DHHS 3264ME is completed by DRO staff and returned to the county eligibility office that issued the OSS slot request.

The county eligibility office completes the approval process by sending the resident a Medicaid Approval Letter (MEDS ELD018). A copy of the letter is sent to the CRCF where the resident is residing. An example of this letter can be found in Section 4 of this manual.

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Notice of Admission

The county eligibility office initiates a Notice of Admission, Authorization & Change of Status For Community Residential Care Facility (DHHS CRCF-01) by completing Section I (Client Information) and Section II B&C (Countable Income and Personal Needs Allowance). This form is signed and dated by the county eligibility worker and sent to the facility. (An example of the form can be found in Section 4.)

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

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

A preadmission flowchart can be found in Section 4.

Personal Needs Allowance

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

The personal needs allowance must be deducted from other income the resident receives, and must be credited to the resident at the beginning of each month. The personal needs allowance is not deducted from the OSS payment.

Bed Holds – Medical Absence

In the event that a resident is temporarily absent from the facility because of a medical confinement (hospitalization, admission to a nursing facility, admission to a mental health facility, etc.), the OSS benefit payment may continue if all the following conditions are met:

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Bed Holds – Medical Absence (Cont'd.)

1. The absence from the facility is expected to last less than 30 consecutive calendar days.
2. The facility obtains a physician's certification of the need for the medical confinement and the expected length of absence from the facility.
3. The facility or resident obtains a statement from the resident of the need for the continuation of the OSS payment.
4. The facility submits a DHHS CRCF-01 to the OSS program manager with Sections I and III completed accurately and the form signed by the facility representative.

For continued benefit payment, the facility must submit an accurately completed DHHS CRCF-01 within 10 days of the OSS beneficiary's admission to the medical facility.

The form should be sent to the OSS program manager at the address below:

Division of Community and Facility Services
Department of Health and Human Services
Post Office Box 8206
Columbia, SC 29202

Supporting documentation specified above (Items 1 – 4) must be included with the request. This information may also be sent by fax to (803) 898-4509. The OSS program manager will issue a written response to the resident with a copy sent to the facility and the county eligibility office.

OSS payments during a temporary absence due to a medical confinement are limited to a maximum of 30 days. If the OSS payment is being continued during a temporary absence due to a medical confinement, no other person is allowed to occupy the resident's space during that time period.

If a resident enters a medical facility and is expected to be absent from the CRCF longer than 30 consecutive calendar days, the facility must notify the DRO and eligibility office within 72 hours via the DHHS CRCF-01. The resident must be terminated from the TAD as a discharge, effective the day of the medical facility admission. Reimbursement cannot be claimed for the date of discharge.

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Bed Holds – Medical Absence (Cont'd.)

If a resident who receives SSI has a medical absence, the facility must notify SSA of the absence when it occurs.

Examples

The following scenarios illustrate some possible applications of this policy:

Case 1 A resident has a severe medical/psychiatric crisis and is admitted to an acute care setting; he or she is not expected to return to the CRCF. The facility completes a DHHS CRCF-01 and discharges the resident effective the date of transfer. The facility immediately sends a copy of the DHHS CRCF-01 to the DRO and another copy to the county eligibility office so that another applicant can be issued that client's slot by the DRO, and so the eligibility office can notify SSA of the client's new location.

Case 2 A resident enters the hospital on November 5 and is expected to return to the CRCF after a brief hospitalization. The resident returns on November 13. The medical absence policy does not apply because the resident's hospitalization did not extend beyond the 10-day notification requirement. No action is required by the CRCF.

Case 3 A resident enters the hospital on November 27 and is expected to stay in the hospital for approximately 30 days. The CRCF implements the medical absence policy and submits the required information to the OSS program manager by December 5.

Case 4 A resident enters the hospital on November 27 and is expected to stay for approximately 30 days (as above). The CRCF has submitted the medical leave information and received approval from the OSS program manager for the medical absence. The resident dies while in the hospital. On December 12, the facility completes the DHHS CRCF-01 and discharges the resident effective December 12. The facility immediately sends a copy of the DHHS CRCF-01 to the DRO and another copy to the county eligibility office. The

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Examples (Cont'd.)

facility retains a copy to send in with its TAD for payment processing.

Case 5 A resident enters the hospital and is expected to stay longer than 30 days. The facility completes a DHHS CRCF-01 and discharges the resident effective the date of transfer. The facility immediately sends a copy of the DHHS CRCF-01 to the DRO and another copy to the county eligibility office so that another applicant can be issued that client's slot by the DRO and the eligibility office can notify SSA of the client's new location. The facility retains a copy to send in with its TAD for payment processing.

Bed Holds – Non-Medical Absence

The non-medical absence policy applies only to residents also enrolled in the Integrated Personal Care (IPC) program and occurs when a resident is temporarily absent from the CRCF for a non-medical reason.

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

Reimbursement for IPC services is not allowed for any non-medical resident absence from the CRCF; payment reverts to the OSS daily rate for any days the resident is away from the facility.

Examples

The following scenarios illustrate some possible applications of this policy:

Case 1 A resident goes to a family member's home for a temporary stay during the holidays. The resident leaves on December 22 and returns on December 27. The resident was away from the CRCF for four days and cannot receive IPC reimbursement for those four days. The facility completes a DHHS CRCS-01 and sends a copy with the TAD the following month. The facility indicates the absence on the Daily Census Log and faxes or mails a copy of the log to the regional DHHS nurse on or before the 10th day of the following month (January 10).

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Examples (Cont'd.)

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

Resident Transfer

The OSS program slot allocation allows a beneficiary to transfer from one CRCF to another at any time during his or her stay as long as the new facility agrees to accept the beneficiary and is enrolled as an OSS program participant. The assigned OSS slot will transfer with the resident to the new facility. The receiving facility should request verification of the OSS beneficiary's eligibility status before accepting him or her as a new resident.

Eligibility verification may be obtained by calling the county eligibility office or the Interactive Voice Response System (IVRS). Information on the IVRS system can be found in Section 1 of this manual.

A transfer flowchart can be found in Section 4 of this manual.

Current CRCF Discharges Resident

Within 72 hours of the discharge, the current facility initiates a DHHS CRCF-01 by completing Section I and applicable information in Section II D. Copies of this DHHS CRCF-01 are sent to the county eligibility office and the DRO. The original form is attached to the monthly TAD after making the necessary changes on the TAD. **Reimbursement cannot be claimed for the date of discharge.**

Receiving CRCF Admits Resident

Within 72 hours of the admission, the new/receiving facility initiates a DHHS CRCF-01 by completing Section I and applicable information in Section II A&B and sends the DHHS CRCF-01 to the county eligibility office.

The eligibility office reviews Section I and Section II A&B and completes Section II C. The eligibility caseworker signs, dates, and returns the DHHS CRCF-01 to the facility and sends a copy of the DHHS CRCF-01 to the DRO. The receiving facility attaches the DHHS CRCF-01 to the monthly TAD, and makes the necessary changes, which, in the case of a transfer, would be the addition of a new resident to the TAD. **Reimbursement may be claimed for the date of admission.**

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Resident Discharge

Resident Moves Out of the Facility or Dies

Within 72 hours, the facility initiates the DHHS CRCF-01, completing Section I and the appropriate field in Section II E. Copies are sent to the county eligibility office and to the DRO. The facility attaches the original DHHS CRCF-01 to the monthly TAD and makes necessary changes. Reimbursement cannot be claimed for the date of discharge.

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

Resident Loses OSS Eligibility

The eligibility office initiates the DHHS CRCF-01 by completing Section I and Section II E and providing a written explanation in the "Other Reasons for Termination" section, such as "Resident is no longer OSS eligible due to income change."

The eligibility office forwards the DHHS CRCF-01 to the facility and sends a copy to the DRO. The facility attaches the original DHHS CRCF-01 to the monthly TAD and makes necessary changes. The termination date is the last day of OSS eligibility or the date of discharge, whichever is earlier. The DRO updates the data system when any of these changes are made.

A discharge flowchart can be found in Section 4 of this manual.

Income Changes

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

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PROGRAM REQUIREMENTS

PROVIDER QUALIFICATIONS

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

- Provide evidence of licensure in good standing as a Community Residential Care Facility (CRCF) by the Department of Health and Environmental Control (DHEC)
- Properly and accurately complete the facility enrollment information on the OSS Enrollment Data Form (DHHS Form 219-RCF)
- Properly and accurately complete the information on the Authorization Agreement for Electronic Funds Transfer and attach a voided check
- Comply with all requirements in the Facility Participation Agreement for the South Carolina Optional State Supplementation (OSS) program found on DHHS 219-RCF

Facility Licensure

The South Carolina Department of Health and Environmental Control (DHEC), Division of Health Licensing, is the licensing authority for the state. Licensing regulations are set by Regulation 61-84 (revised 07/21/01). A facility that wishes to become licensed must contact the Division of Health Licensing at (803) 545-7202.

Facility Enrollment

A facility must enroll in the OSS program with DHHS before receiving reimbursement for OSS residents. A facility may request an enrollment package by calling (803) 788-7622, ext. 41650, or by writing to the OSS Enrollment address given below.

The facility's authorized representative is required to accurately complete, date, and sign all pages of the DHHS 219-RCF and to accurately complete the Authorization Agreement for Electronic Funds Transfer (EFT), including the attachment of a voided check (See Section 3 for more details). These completed forms should be mailed to:

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Facility Enrollment (Cont'd.)

OSS Enrollment
Post Office Box 8809
Columbia, SC 29202-8809

When DHHS receives an accurately completed enrollment form and EFT form, the facility will be issued an official notification of enrollment identifying the participating facility's assigned identification number. This identification number must be used on all communication regarding OSS payments and other documents. An OSS manual will also be sent to the newly enrolled facility, and a provider inservice will be scheduled by the OSS program staff.

Facility Participation Agreement and Sanctioning Process

The Facility Participation Agreement and Sanctioning Process is part of the DHHS 219-RCF. Key elements include:

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

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Facility Participation Agreement and Sanctioning Process (Cont'd.)

By signing each page of the DHHS 219-RCF, including a signature on each page of the Facility Participation Agreement and Sanctioning Process, the facility representative acknowledges that the execution of the Facility Participation Agreement makes the facility **eligible** to participate in the OSS program. The facility is not guaranteed any specific level of OSS participation.

An example of DHHS Form 219-RCF can be found in Section 4 of this manual.

Cost Reports

Each CRCF participating in the OSS program is required to submit a standardized cost report, developed by DHHS, which reflects all income and operating costs of the facility.

The CRCF must submit a standardized cost report to remain eligible to participate in the OSS program. Facilities failing to submit cost reports by the required due date will not be eligible to participate in the OSS program. Cost reports cover the period of operation from July 1 through June 30 of each year. The due date is specified by the DHHS Division of Long Term Care Reimbursements each year.

Freedom of Choice

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

BENEFICIARY REQUIREMENTS

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

An individual may be eligible to participate in the OSS program if he or she currently receives SSI. In this case, completion of an application to determine eligibility is not necessary. However, the SSI beneficiary must read and sign a short statement that he or she wishes to enter an enrolled facility. This procedure may be completed at the eligibility office of the county in which the beneficiary resides or may be completed by mail. A copy of this form (The SSI Recipient Request for Optional State Supplementation) is located in Section 4 of this manual.

If an individual is not receiving SSI, an OSS application must be completed and eligibility determined by the county

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BENEFICIARY REQUIREMENTS (CONT'D.)

eligibility office. An application may be completed at any county eligibility office and most hospitals. At the time an application is made, the following information should be presented for verification:

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

For reference, a list of all county eligibility offices is located in Section 4 of this manual.

Eligibility Criteria

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

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

If the eligibility office finds that an applicant does not meet requirements and denies him or her financial eligibility, an appeal may be filed. The appeal must be filed in writing, within 30 days of the date of notice. The DHHS Division of Appeals will handle these appeals.