2017 Optional State Supplementation (OSS) Program

SCDHHS
Community and Facility Services
PO Box 8206
1801 Main Street
Columbia, SC 29202-8206

SCDHHS Department Roles & Contact Numbers

Resident's Medicaid Status

Eligibility

- Approve or Deny OSS application
- Initiate CRCF-01 form and Cost of Living Adjustment (COLA) forms
- Provide answers for eligibility questions

888-549-0820

OSS or OSCAP Polices

OSS Program Staff

- Develop policies
- Daily operations of budget, training, rates
- OSCAP contracts

803-898-2590

Update facility information

Provider Enrollment/Provider Service Center

- Update address, telephone numbers, etc.
- Direct Deposit
- Change of Ownership

888-289-0709 option 4

Billing/payment information

Medicaid Claims Control System (MCCS)

- TAD questions
- Edit Codes questions
- Billings/payment questions
- Register for training

888-289-0709 option 3

Nurses Consultants

Vacant Counties: Lancaster, Marlboro, Chesterfield, Horry, Florence, Darlington, Dillon, Marion	Sandra Jones, RN (803) 605-7129 jonessa@scdhhs.gov Counties: Williamsburg, Georgetown, Berkeley, Dorchester, Colleton, Jasper, Hampton, Allendale, Barnwell, Charleston, Beaufort	Darlene Newton, RN (864) 617-0108 Regina.newton@scdhhs.gov Counties: Oconee, Pickens, Greenville, Anderson, Abbeville, McCormick
Jai-Netta Montgomery, RN (803) 667-5598 Jai-Netta.Montgomery@scdhhs.gov Counties: Aiken, Lexington, Richland, Fairfield, Chester, York, Edgefield	Charlena Hunter, RN (803) 457-2656 Charlena.Hunter@scdhhs.gov Counties: Bamberg, Orangeburg, Calhoun, Clarendon, Sumter, Lee, Kershaw	Quantina Williams, RN (864) 323-5627 Quantina.Williams@scdhhs.gov Counties: Spartanburg, Cherokee, Union, Laurens, Newberry, Greenwood, Saluda

Program Contact Information

Terrell McMorris, MSW
OSS Program Coordinator
Terrell.McMorris@scdhhs.gov
Office: (803) 898-1810

Alexis Martin, MBA, CPM
OSS Program Manager
martina@scdhhs.gov
Office: (803) 898-1060

Candice Smith-Byrd, CPC
Quality Assurance Manager
smithbc@scdhhs.gov
Office: (803)-898-3372

WHAT IS OPTIONAL STATE SUPPLEMENTATION (OSS)?

- OSS is an entitlement program that is a state supplement to a person's Security Income [Supplemental Security Income (SSI)/Social Security Administration (SSA)]. The South Carolina Department of Health and Human Services (SCDHHS) pays the difference between the OSS rate and the Social Security payment.

- The purpose of this program is to provide reimbursement to enrolled CRCFs (also known as Assisted Living Facilities) that provide room and board and a degree of personal care for eligible consumers. OSS is NOT a Medicaid program; it is funded at 100% state funding.

SOUTH CAROLINA Healthy Connections MEDICAID

OSS Program

- Facilities must accept the OSS entitlement amount as payment in full.

- Facilities may not charge a resident or a resident's family for any difference over and above the OSS entitlement amount – even if the family is willing to pay the difference for a private room.

- The additional payment would be considered income for the resident and could make the resident ineligible for OSS due to income limitations.

Resident Assessments

- Medical assessments are required for all OSS and OSCAP participants.

- Assessments will be performed by a SCDHHS nurse at the CRCF where the residents reside. The resident's assessment will occur after admission into the facility and every **24 months thereafter for OSS residents and every 18 months for OSCAP residents.**

Questions…….

- What is Optional State Supplementation?

- What agency is responsible for Optional State Supplementation?

OSS Steps for New Admission

Step 1: Who is OSS Eligible?

- Be 65 years or older, ***or*** 18 years of age or older and blind or disabled
- Be a U.S. citizen or qualified noncitizen
- Have a Social Security number or file for one
- File for any other benefits to which they may be entitled
- Effective January 1, 2017 meet net income limit of $1,420
- Can't exceed resource limit of $2,000 for an individual

QUICK FACTS

Number of Consumers 3,338 (OSS & OSCAP)

49% Female & 51% Male

Average Age: 63

CRCF Medicaid enrolled facilities: 313

Average Income: $811

Recurring Income :

SSA: 43%

SSI: 59%

<u>Top 5 Primary Diagnoses</u>

1. **Hypertension**
2. **Schizophrenia**
3. **Diabetes**
4. **Hyperlipidemia**
5. **Dementia**

Step 2: OSS Check Eligibility

1. Visit The Web Tool https://portal.scmedicaid.com/
2. Enter your username and password
3. From the Menu, click **Eligibility,**
4. From the submenu choose **Single Query**, to retrieve the *Eligibility Verification Inquiry* screen.

5. Enter the one of the following in the fields indicated: Medicaid I.D.; SSN and Date of Birth; or Name and Date of Birth along with the Date of Service (auto populates with today's date).

Note: The Web Tool will return SSN information only if you search eligibility using SSN.

6. Click the **Check Eligibility** button. The *Eligibility Verification Inquiry: Selection Summary* screen will appear. Place a check mark in the box beside the beneficiary's Medicaid ID number.

7. Click the **Display** button. The *Eligibility Verification Results* screen will appear which contains the eligibility information of the beneficiary in question.

- If you wish to check eligibility for another recipient, click the **Back** link. This will return you to the original screen.
- If you wish to add this individual to your Beneficiary List, click the **Add Beneficiary** link.

Step 3: What documentation is needed when completing an OSS application?

Forms

- 3401 –No active Medicaid
- 3400A has active Medicaid www.scdhhs.gov/sites/default/files/FM%203400.pdf
- 1728 is receiving SSI only
- Send Medicaid Eligibility Applications to:

Fax:* *888-820-1204

or

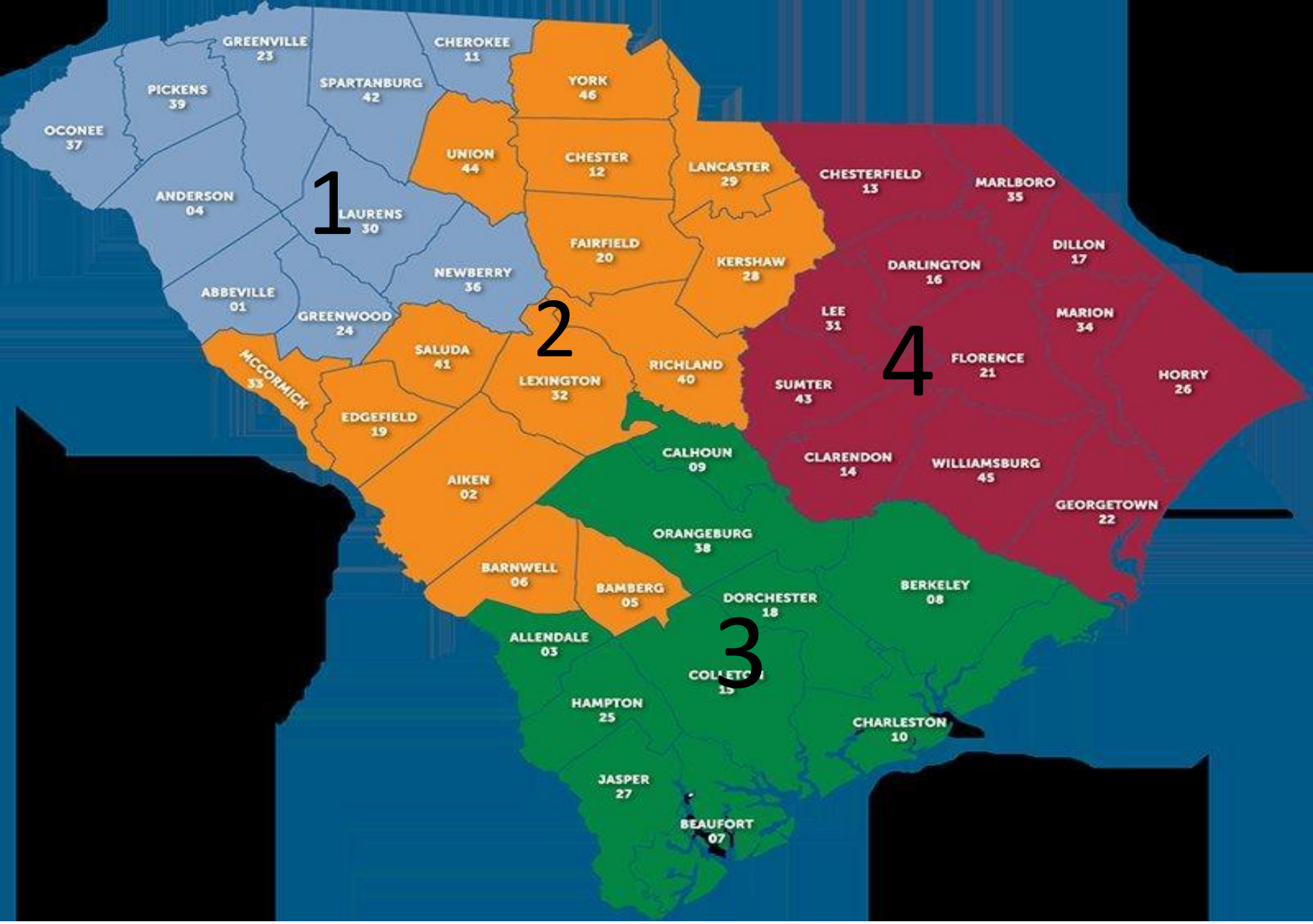
Mail: *SCDHHS*
Central Mail
PO Box 100101
Columbia, SC 29202

1. 30 day bank statement from previous month
2. Life Insurance policy (cash value and dividends) as of the 1st of the month
3. Burial Contract
4. Signed Authorized Representative form
   (Form 1282)
5. Client has to sign Form 943
   (Information for Release Form)
6. Health Insurance Card (Medicare, VA, Pension) and award amounts
7. Current recurring income amount from SSA/Pension
8. Property owner have correct address and tax notice (intent to return home)

LTC Workers

- List of Long Term Care Coordinators (LTCCs) responsible for serving counties identified in their region throughout the state.
- The state is divided into four (4) regions.
- To determine your points of contact, use the following map and identify the county in which your facility is located. Next, locate your LTCCs as listed. For example, if your facility is located in Richland County, you should contact our Region 2 team, Leighann and Melanie

Region	LTC Worker	Email	Phone Number
1 – Blue	Teena Bixler	BixlerT@scdhhs.gov	864-250-5897
1 – Blue	Kathi Dixon	DixonK@scdhhs.gov	864-229-5258
2- Orange	Leighann Pfannestiel	Pfannla@scdhhs.gov	803-898-3093
2 – Orange	Melanie Turner	TurnerMe@scdhhs.gov	803-914-1662
3- Green	Perry Foss	Foss@scdhhs.gov	843-584-4066
3- Green	JoAnn Kearse	KearseJ@scdhhs.gov	843-740-5925
4- Red	LaRonna Bryant	Faulklar@scdhhs.gov	843-667-8718 x47
4- Red	Meko Williams	willmeko@scdhhs.gov	803-435-4305 x229


GREENVILLE
23
CHEROKEE
11
PICKENS
39
SPARTANBURG
42
YORK
46
OCONEE
37
UNION
44
CHESTER
12
LANCASTER
29
CHESTERFIELD
13
MARLBORO
35
ANDERSON
04
1
LAURENS
30
FAIRFIELD
20
KERSHAW
28
DARLINGTON
16
DILLON
17
NEWBERRY
36
ABBEVILLE
01
GREENWOOD
24
2
LEE
31
MARION
34
SALUDA
41
RICHLAND
40
4
FLORENCE
21
MCCORMICK
33
LEXINGTON
32
SUMTER
43
HORRY
26
EDGEFIELD
19
CALHOUN
09
CLARENDON
14
WILLIAMSBURG
45
AIKEN
02
GEORGETOWN
22
ORANGEBURG
38
BARNWELL
06
BAMBERG
05
DORCHESTER
18
BERKELEY
08
ALLENDALE
03
3
HAMPTON
25
CHARLESTON
10
JASPER
27
BEAUFORT
07

Contacting Eligibility

- When you need to know the status of an OSS application please call 888-549-0820.
- Inform the customer service representative you are calling to check on the OSS status and give them the date in which you applied.
- The OSS program area cannot provide you with the status of your application.

Step 4: CRCF-02 Form

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Henry McMaster GOVERNOR
Deirdra T. Singleton ACTING DIRECTOR
P.O. Box 8206 > Columbia, SC 29202
www.scdhhs.gov

Date

Dear

CLTC #

Your financial eligibility has been approved for the Optional State Supplementation (OSS) program. As of the above date, you may select a licensed community residential care facility (CRCF) that participates in the OSS program. If you need assistance locating OSS enrolled CRCF's in South Carolina please visit www.nfbl.sc.gov . Please take this notification to the CRCF you selected. This letter is valid for 30 calendar days from the date of the letter. If you are not admitted by _____, you must reapply for OSS at your DHHS County Office. The CRCF must complete the bottom portion of this form on the day you are admitted and return it to the address listed below.

SECTION II

TO BE COMPLETED BY A LICENSED COMMUNITY RESIDENTIAL CARE FACILITY ENROLLED INTHE OSS PROGRAM:

Instruction for CRCF: Complete and return this form to CLTC area office:
South Carolina Department of Health and Human Services
OSS Program –J9
P.O. BOX 8206
Columbia, SC 29202-8206
Or
Fax to 803-255-8209

Please note that a delay in returning this from incorrect information or blanks in Section II will result in a delay of the OSS Payment to your facility.

CRCF Name:_____
CRCF Provider Number: RC ___ ___ ___ ___
Date resident entered Facility: __ __ /__ __/ __ __ __ __
Dated Completed: / /
Signature and Title of CRCF Official:_____

Signature and Date of OSS-Staff _____

SCDHHS CRCF-02 Form

Added Fax number to CRCF-02 Form

Step 5: Initial CRCF-01 Form

Healthy Connections
South Carolina Department of Health and Human Services

Optional State Supplementation (OSS)
Slot Reservation Request
Notice of Admission, Authorization & Change of Status for Community Residential Care Facility

RESET FORM

Reason for Submission: Initial

Section I. Identification of Applicant/Resident (CRCF Staff)

1. Applicant/Resident's Name (First, Middle, Last): John Doe	2. Birth Date (MO-DY-YY): 12/31/1917	3. Medicaid No. (10 digits): 1 2 3 4 5 6 7 8 9 0
4. CRCF Name: ABCDE Facility	6. County of Residence: 40	7. Social Security No.: 1 2 3 - 4 5 - 6 7 8 9
5. CRCF Street Address: Happy Street	8. CRCF Provider ID#: R C 0 0 0 0	9. Date of Request: 05/23/2017
City: Columbia / State: SC / ZIP: 29201		
10. Authorized Representative's Name: Terrell Smith	12. Authorized Representative's Street Address: Byrd Dr.	
11. Authorized Representative's Phone No.: 803-777-9311	City: Columbia / State: SC / ZIP: 29201	

Section II. Verification of OSS Slot Authorization and CRCF Admission (Completed by CLTC)

1. Date Applicant Entered CRCF	2. Authorization Date	3. CLTC Worker Name	4. ☐ Applicant Did Not Enter CRCF

Section III. Completed by CRCF Facility

(A) Transferred to: Choose One — Transfer Date:
Name of new CRCF or institution:

(B) Terminated/Discharged: Choose One — Termination Date:
Specify reason for case termination or other change in status if not covered by above items:

(C) Bed Holds: Choose One
Start Date _____ End Date _____
Start Date _____ End Date _____
Start Date _____ End Date _____

* **REMINDER: DATE OF ADMISSION IS BILLED. DATE OF DISCHARGE IS NOT.**

Section IV. Verification of Medicaid Status (Completed by DHHS EEMS – Eligibility)

1. Application Date: 05/23/2017 (MO-DD-YYYY)

2. Medicaid Status
- ☒ SSI Recipient
- ☐ Financially eligible awaiting OSS slot authorization
- ☐ Denied: Incomplete app.
- ☐ Financially Ineligible

(A) Authorization to Begin Payment: 06/01/2017 (MO-DD-YYYY)

(B) Resident's Countable Income Effective: 06/2917 (MO-YYYY) $ 735.00 Personal Needs Amount $ 67

Section V – Signature

Happy Feet
Eligibility Worker Name (Print)

Happy Feet
Authorized Eligibility Worker Signature

05/25/2017
Date

DHHS Form CRCF-01 (July 2015)

Step 6: Add Resident to TAD

REPORT NH454SR1 — SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES — PAGE 1
DATE 06/25/2013 — COMMUNITY RESIDENTIAL CARE — FOR MONTH OF JUNE

CRCF NO. RC0099 Happy Home
111 Valley St
Lexington SC 29687

ENTER CHANGES

LINE	COUNTY	RECIPIENT NAME	RECIPIENT ID NO	MONTHLY INCOME	DATE OF SERVICE MO/YR	CRCF DAYS	OSCAP DAYS // CHANGED CRCF DAYS	CHANGED OSCAP DAYS	DELETE FROM NEXT MONTH'S TAD
01		Mary Smith	1234567801		02/03	28			
02		Sam Perkins	9786543201		02/03		28		
03									
04									
05		**John Doe**	**1234567890**		**02/17**	**28**			
06									
07									
08									
09									
10									
11									
12									
13									

- The Initial CRCF 01 form must be attached to the monthly Turn Around Document (TAD) and add the new resident's name to the last page of the TAD.
- A copy is kept for the facility's files.

Current Resident Status Change Steps

When an OSS resident transfers To your facility from another CRCF?

1. Verify that the resident is already participating in the OSS program by checking Web Tool.

2. Complete a Status Change CRCF-01 Form. Complete Section I and submit to Terrell McMorris at Terrell.McMorris@scdhhs.gov or Fax to **803-255-8209**

3. Allow **5** business days for a return forms . Please keep a copy for your records.

Healthy Connections

South Carolina Department of Health and Human Services

Optional State Supplementation (OSS)
Slot Reservation Request
Notice of Admission, Authorization & Change of Status for Community Residential Care Facility

RESET FORM

Reason for Submission: Status Cha

Section I. Identification of Applicant/Resident (CRCF Staff)

1. Applicant/Resident's Name (First, Middle, Last)	2. Birth Date (MO-DY-YY)	3. Medicaid No. (10 digits)
John Doe	01/01/1917	1 2 3 4 5 6 7 8 9 0
4. CRCF Name: Great CRCF	6. County of Residence: 40	7. Social Security No.: 1 2 3 - 4 5 - 6 7 8 9
5. CRCF Street Address: 123 Awesome Ct	8. CRCF Provider ID#: R C 0 0 0 0	9. Date of Request: 05/23/2017
City: Columbia / State: SC / ZIP: 29216		
10. Authorized Representative's Name	12. Authorized Representative's Street Address	
11. Authorized Representative's Phone No.	City / State / ZIP	

Section II. Verification of OSS Slot Authorization and CRCF Admission (Completed by CLTC)

1. Date Applicant Entered CRCF	2. Authorization Date	3. CLTC Worker Name	4. ☐ Applicant Did Not Enter CRCF

Section III. Completed by CRCF Facility

(A) Transferred to: Choose One Transfer Date:

Name of new CRCF or institution:

(B) Terminated/Discharged Choose One Termination Date:

Specify reason for case termination or other change in status if not covered by above items:

(C) Bed Holds Choose One

Start Date _____ End Date _____

Start Date _____ End Date _____

Start Date _____ End Date _____

* **REMINDER: DATE OF ADMISSION IS BILLED. DATE OF DISCHARGE IS NOT.**

Section IV. Verification of Medicaid Status (Completed by DHHS EEMS - Eligibility)

1. Application Date _____ MO-DD-YYYY

2. Medicaid Status

☐ SSI Recipient ☐ Denied: Incomplete app.

☐ Financially Ineligible ☐ Financially eligible awaiting OSS slot authorization

(A) Authorization to Begin Payment _____ MO-DD-YYYY

(B) Resident's Countable Income Effective _____ MO-YYYY $ _____ Personal Needs Amount $ _____

Section V – Signature

_____
Eligibility Worker Name (Print)

_____ _____
Authorized Eligibility Worker Signature Date

When an OSS resident transfers From your facility to another CRCF?

- **Complete the following steps:**
  1. Complete a Status Change CRCF-01 Form Sections I and III.
  2. Send the CRCF-01 form to Ms. Terrell McMorris via email at Terrell.McMorris@scdhhs.gov or fax to 803-255-8209
  3. Once a signed CRCF-01 Form is received, remove the resident's name from the TAD by placing an X in the delete column on the TAD and submit a copy of the signed CRCF-01 Form.

Healthy Connections

South Carolina Department of Health and Human Services

Optional State Supplementation (OSS) Slot Reservation Request Notice of Admission, Authorization & Change of Status for Community Residential Care Facility

RESET FORM

Reason for Submission: Status Cha

Section I. Identification of Applicant/Resident (CRCF Staff)

1. Applicant/Resident's Name (First, Middle, Last)	2. Birth Date (MO-DY-YY)	3. Medicaid No. (10 digits)
John Doe	01/01/1917	1 2 3 4 5 6 7 8 9 0
4. CRCF Name Great CRCF	6. County of Residence 40	7. Social Security No. 1 2 3 - 4 5 - 6 7 8 9
5. CRCF Street Address 123 Awesome Ct	8. CRCF Provider ID# R C 0 0 0 0	9. Date of Request 05/23/2017
City: Columbia / State: SC / ZIP: 29216		
10. Authorized Representative's Name	12. Authorized Representative's Street Address	
11. Authorized Representative's Phone No.	City / State / ZIP	

Section II. Verification of OSS Slot Authorization and CRCF Admission (Completed by CLTC)

1. Date Applicant Entered CRCF	2. Authorization Date	3. CLTC Worker Name	4. ☐ Applicant Did Not Enter CRCF

Section III. Completed by CRCF Facility

(A) Transferred to: CRCF Transfer Date: 05/23/2017

Name of new CRCF or institution: **Love CRCF**

(B) Terminated/Discharged Choose One Termination Date:

Specify reason for case termination or other change in status if not covered by above items:

(C) Bed Holds Choose One

Start Date _____ End Date _____

Start Date _____ End Date _____

Start Date _____ End Date _____

* **REMINDER: DATE OF ADMISSION IS BILLED. DATE OF DISCHARGE IS NOT.**

Section IV. Verification of Medicaid Status (Completed by DHHS EEMS - Eligibility)

1. Application Date _____ MO-DD-YYYY

2. Medicaid Status

☐ SSI Recipient ☐ Denied: Incomplete app.

☐ Financially Ineligible

☐ Financially eligible awaiting OSS slot authorization

(A) Authorization to Begin Payment _____ MO-DD-YYYY

(B) Resident's Countable Income Effective _____ MO-YYYY $ _____ Personal Needs Amount $ _____

Section V – Signature

_____

Eligibility Worker Name (Print)

_____ _____

Authorized Eligibility Worker Signature Date

When a resident terminates from your facility

1. Complete the CRCF-01 Form Sections I and III (B).

2. Select the reason for termination and enter the date of termination.

3. Submit a copy of this form with your TAD and place an X in the delete column on the TAD and fax copy to eligibility department **888-820-1204.**

4. **No Signature** is needed for terminations on the CRCF-01 Form.

Healthy Connections
South Carolina Department of Health and Human Services

Optional State Supplementation (OSS) Slot Reservation Request Notice of Admission, Authorization & Change of Status for Community Residential Care Facility

RESET FORM

Reason for Submission: Status Cha

Section I. Identification of Applicant/Resident (CRCF Staff)

1. Applicant/Resident's Name (First, Middle, Last)			2. Birth Date (MO-DY-YY)	3. Medicaid No. (10 digits)
John Doe			01/01/1917	1 2 3 4 5 6 7 8 9 0
4. CRCF Name Great CRCF			6. County of Residence 40	7. Social Security No. 1 2 3 - 4 5 - 6 7 8 9
5. CRCF Street Address 123 Awesome Ct			8. CRCF Provider ID# R C 0 0 0 0	9. Date of Request 05/23/2017
City Columbia	State SC	ZIP 29216		
10. Authorized Representative's Name			12. Authorized Representative's Street Address	
11. Authorized Representative's Phone No.			City	State / ZIP

Section II. Verification of OSS Slot Authorization and CRCF Admission (Completed by CLTC)

1. Date Applicant Entered CRCF	2. Authorization Date	3. CLTC Worker Name	4. ☐ Applicant Did Not Enter CRCF

Section III. Completed by CRCF Facility

(A) Transferred to: Choose One Transfer Date:

Name of new CRCF or institution:

(B) Terminated/Discharged due to Death Termination Date: 05/23/2017

Specify reason for case termination or other change in status if not covered by above items:

(C) Bed Holds Choose One Start Date _____ End Date _____

Start Date _____ End Date _____

Start Date _____ End Date _____

* **REMINDER: DATE OF ADMISSION IS BILLED. DATE OF DISCHARGE IS NOT.**

Section IV. Verification of Medicaid Status (Completed by DHHS EEMS - Eligibility)

1. Application Date _____ MO-DD-YYYY

2. Medicaid Status

☐ SSI Recipient ☐ Denied: Incomplete app.

☐ Financially Ineligible ☐ Financially eligible awaiting OSS slot authorization

(A) Authorization to Begin Payment _____ MO-DD-YYYY

(B) Resident's Countable Income Effective _____ MO-YYYY $ _____ Personal Needs Amount $ _____

Section V – Signature

_____
Eligibility Worker Name (Print)

_____ _____
Authorized Eligibility Worker Signature Date

Income Change

Healthy Connections
South Carolina Department of Health and Human Services

Optional State Supplementation (OSS)
Slot Reservation Request
Notice of Admission, Authorization & Change of Status for Community Residential Care Facility

RESET FORM

Reason for Submission: Status Cha

Section I. Identification of Applicant/Resident (CRCF Staff)

1. Applicant/Resident's Name (First, Middle, Last) John Doe	2.Birth Date (MO-DY-YY) 12/31/1917	3. Medicaid No. (10 digits) 1 2 3 4 5 6 7 8 9 0
4. CRCF Name ABCDE Facility	6.County of Residence 40	7. Social Security No. 1 2 3 – 4 5 – 6 7 8 9
5. CRCF Street Address Happy Street	8. CRCF Provider ID# R C 0 0 0 0	9. Date of Request 05/23/17
City: Columbia / State: SC / ZIP: 29201		
10. Authorized Representative's Name Terrell Smith	12. Authorized Representative's Street Address Byrd Dr	
11. Authorized Representative's Phone No. 803-777-9311	City: Columbia / State: SC / ZIP: 29201	

Section II. Verification of OSS Slot Authorization and CRCF Admission (Completed by CLTC)

1. Date Applicant Entered CRCF	2. Authorization Date	3. CLTC Worker Name	4. ☐ Applicant Did Not Enter CRCF

Section III. Completed by CRCF Facility

(A) Transferred to: Choose One — Transfer Date:
Name of new CRCF or institution:

(B) Terminated/Discharged Choose One — Termination Date:
Specify reason for case termination or other change in status if not covered by above items:

(C) Bed Holds Choose One

Start Date _____ End Date _____
Start Date _____ End Date _____
Start Date _____ End Date _____

* REMINDER: DATE OF ADMISSION IS BILLED. DATE OF DISCHARGE IS NOT.

Section IV. Verification of Medicaid Status (Completed by DHHS EEMS - Eligibility)

1. Application Date: 05/23/2017 (MO-DD-YYYY)

2. Medicaid Status
- ☒ SSI Recipient
- ☐ Financially eligible awaiting OSS slot authorization
- ☐ Denied: Incomplete app.
- ☐ Financially Ineligible

(A) Authorization to Begin Payment _____ (MO-DD-YYYY)

(B) Resident's Countable Income Effective 01/01/2017 (MO-YYYY) $ 735 Personal Needs Amount $ 67

Section V – Signature

Happy Feet
Eligibility Worker Name (Print)

Happy Feet
Authorized Eligibility Worker Signature

06/07/17
Date

OSCAP

What is Optional Supplemental Care For Assisted Living Participants?

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

- OSCAP gives additional reimbursement of $207 per month for each qualified resident.

- Current OSCAP rate is $1, 627

SOUTH CAROLINA Healthy Connections MEDICAID

Step 1: Does my OSS resident meet the Medical Necessity Criteria?

- Two (2) functional dependencies
- Limited assistance with two (2) or more Activities of Daily Living (ADLs)

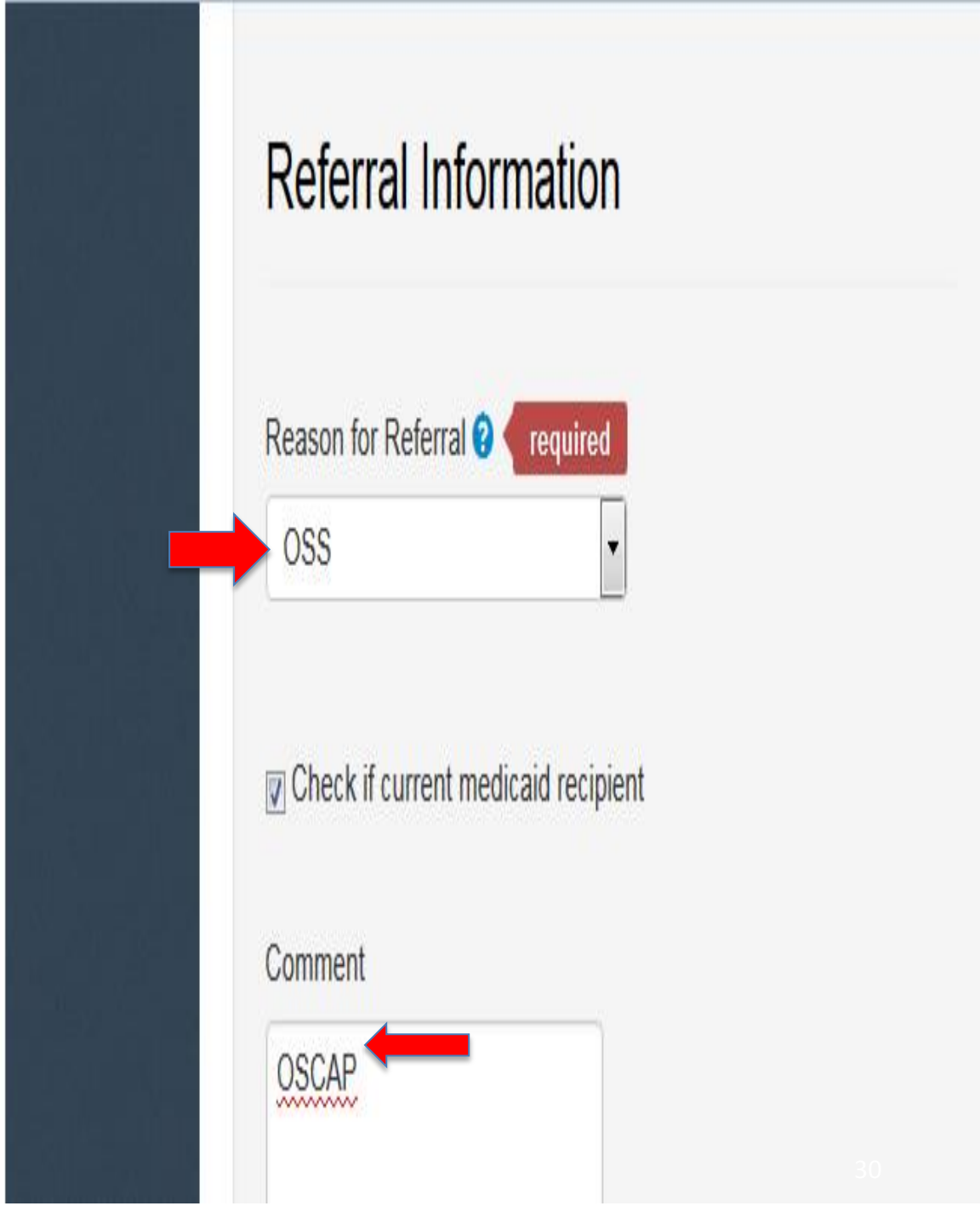
- One (1) cognitive and one (1) functional dependency
- Limited assistance with one (1) or more ADLs in addition to a cognitive impairment

How to apply for OSCAP?

1. Must be OSS approved before you can apply for OSCAP.

2. To complete OSCAP referral visit: https://phoenix.scdhhs.gov/cltc_referrals/new
3. When applying for OSCAP, select OSS as the Reason for Referral. In the comment box type OSCAP.

** OSCAP has not been added as a reason for referral. The correct choice is OSS, but be sure to enter OSCAP in the comment box. Any questions??? Best way to access referral is to google search "CLTC electronic referral" and select the option with Phoenix in the description*



What will the DHHS Nurse need to complete the OSCAP Assessment?

- A SCDHHS nurse will visit your facility to assess referred OSS participants for OSCAP.

- The SCDHHS nurse will need:
  - Copy of Medication Administration Report (MAR)/Physicians Orders
  - Copy of Individual Care Plan (ICP)
  - Resident's chart
  - Recent height, weight, and vital signs
  - Interview with direct care staff
  - Interview resident
- OSCAP assessments are every 18 months, unless there is a change in the level of care.

Status Change Form

- **When should I expect to receive the Status Change Form?**
  The SCDHHS nurse for your region will send the form following her assessment via fax, email, or USPS mail.

- **Do I attach this form to my TAD?**
  You only attach the status form to the TAD if there is an authorization or termination date. A copy should be kept for your records.

- **Should I keep a copy?**
  A copy of the most current status form must be kept in the participant's record.

Optional Supplemental Care for Assisted Living Participants (OSCAP)
STATUS FORM

CRCF Name :
RC Number:
Address:
City, State, Zip

Resident's Name:
Medicaid Number:
SSN:
OSCAP Nurse:

☐ **Participant OSCAP Authorization Date** _____

☐ **Applicant does not meet medical necessity requirements to participate in OSCAP. The participant's eligibility for Optional State Supplementation (OSS) will not be affected.**

☐ **Participant OSCAP Termination Date:** _____

Note: This form should only be submitted with the TAD to the Provider Service Center if there is an authorization or termination date.

Appeal Information:
A resident dissatisfied with the level of care decision by the OSCAP program has the right to request an appeal of the action. The CRCF must assist the resident in providing a timely request for an appeal. The resident, with the assistance of CRCF staff, when needed, must write a letter requesting an appeal within 30 days of the date of the official written notification issued by the OSCAP service and include a copy of the notification being appealed.

The letter should be addressed to:
Appeals and Hearing Division
S.C. Dept. of Health & Human Services
Post Office Box 8206
Columbia, SC 29202-8206

Information regarding the resident's right to appeal and instructions for initiating an appeal are printed on the Notification Form (DHHS Form 171). See the OSS Provider Manual for detail on the appeal process

Date: _____ RN Signature: _____

Service Plan

- A service plan will be individualized for each OSCAP participant by the SCDHHS nurse.
- Service plans will be mailed, emailed, or faxed to the facility following the assessment and level of care determination.
- Service plan must be used as guidance to revise individual care plans and to create the Resident Monthly Task Log.
- A copy must be kept in the resident's file and available to any SCDHHS staff upon request.

Service Plan

COMMUNITY LONG TERM CARE

Service Plan

Participant Name: [redacted]
CLTC Number:
Service Manager: Donna Perry
Service Plan Date: 05/12/2017
Program OSS Program
Diagnoses

Hyperlipidemia
Hyperthyroidism
Stroke

Primary Contact Name: [redacted]
Mobile Phone:
Home Phone:
Other Phone:

Physicians

Dr.Dharmendra Bhas..	Internal medicine
Dr. Mark A. Ciminelli:	Cardiovascular diseases
Dr. Bradley Johnson:	Urology
Dr. Ramesh Bhootha..	Nephrology/esrd

Currently Authorized Waivered Supports
None on file

Non-Waivered Supports
Adult Protection (NW) [redacted]

Medical Section

Participant: [redacted] **Service Plan Date:** 05/12/2017

Problems/Goals

Description	Added by	Dates
Problem: Participant's medical condition needs monitoring. **Goal:** Participant's medical condition will be monitored and medical supervision provided to prevent complications.	Donna Perry	✓ 05/12/2017

Interventions

Description	Added by	Dates
Caregiver/ Participant will adhere to medical regimen.	Donna Perry	✓ 05/12/2017

Service Plan

Description	Added by	Dates
Caregiver will report changes in the participant's condition to doctor.	DONNA J. PERRY	✓ 09/27/2013
Caregiver will keep skin clean and dry.	DONNA J. PERRY	✓ 09/27/2013
Participant will visit doctor as necessary.	DONNA J. PERRY	✓ 09/27/2013

Custom Problems/Goals/Interventions

Description	Added by	Dates
None on file for this section		

Comments

None on file

This section is used to complete the Resident Monthly Task Log

ADL Section

Participant: [redacted] **Service Plan Date:** 09/25/2013

Problems/Goals

Description	Added by	Dates
Problem: Participant needs Extensive assistance with locomotion (walking or wheelchair use). **Goal:** Participant will have safe mobility.	DONNA J. PERRY	✓ 09/27/2013
Problem: Participant needs Limited assistance with bathing. **Goal:** Participant will receive assistance with bathing.	DONNA J. PERRY	✓ 09/27/2013
Problem: Participant needs Limited assistance with dressing. **Goal:** Participant will receive assistance with dressing.	DONNA J. PERRY	✓ 09/27/2013
Problem: Participant needs Limited assistance with toileting. **Goal:** Participant will receive assistance with toileting.	DONNA J. PERRY	✓ 09/27/2013

OSCAP Task Logs

- The initial OSCAP Task Log must be created by the CRCF licensed nurse. The CRCF nurse must review, revise, sign and date each monthly task log at least every 90 days.
- Must be completed on all OSCAP residents and kept on record.
- All direct care staff in contact with residents must initial all completed tasks.
- **Administrator** or designee must sign and date **weekly.**
- **CRCF nurse** must write a detailed nurse's **note/summary every three (3) months** including: height, weight, vital signs, functional/cognitive dependencies, any behavioral problems and any medical complications following face to face interaction.

Resident Monthly Task Log

Name: John Resident **Room No.** 21 **Medicaid No.** 1234567890

		Activity	Level	Year: 2017 Month: July																															
				01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Transfer	☐	Lifted manually/mechanically																																
	☐	Transfer aid																																
	☐	Weight bearing																																
Locomotion	☐	Wheelchair/Cane/Walker																																
	☒	Other person wheels	E																															
	☐	Put on prosthesis or brace																																
	☐	Wandering																																
Bathing	☐	Does not bathe appropriately																																
	☐	In/out of tub/shower																																
	☐	Lower body/Upper body																																
	☒	Cueing	L																															
Dressing	☐	Buttons/zippers/snaps/tying																																
	☐	Inappropriate dressing/layers																																
	☐	Step by step guidance	L																															
	☒	Refuses to change/reapplies dirty																																
	☐	Put on socks/shoes																																

Level of Care Key: L = Limited E= Extensive T=Total

Problems/Goals

Description

Problem: Participant needs Extensive assistance with locomotion (walking or wheelchair use).
Goal: Participant will have safe mobility.

Problem: Participant needs Limited assistance with bathing.
Goal: Participant will receive assistance with bathing.

Problem: Participant needs Limited assistance with dressing.
Goal: Participant will receive assistance with dressing.

Problem: Participant needs Limited assistance with toileting.
Goal: Participant will receive assistance with toileting.

Resident Monthly Task Log

- All direct care staff in contact with resident should initial all completed tasks.

Bladder & Bowel	☐	Scheduled toileting plan																																					
	☒	Pads/briefs used	L	DD	DD		DD																																
	☐	Bowel program																																					
Cognitive	☐	Memory problem(s)																																					
	☐	Decision making capacity																																					
	☐	Mood problem(s)																																					
	☐	Behavior problem(s)																																					
Diet	☐	Good (75%) →																																					
	☐	Fair (50%) →																																					
	☐	Poor (25%) →																																					
	☐	Refused →																																					
	☐	Supplements→																																					
Level of Care Key: L = Limited E= Extensive T=Total																																							

Signatures and Initials of all Resident Assistants providing assistance this month.

Initials	Signatures
DD	Donald Duck

Initials	Signatures

Resident Monthly Task Log

Weight & Vital Signs		Date & Results	Date & Results	Date & Results	Date & Results	Date & Results	Date & Results
☐	Weight →						
☐	Blood Pressure →						
☐	Temperature →						
☐	Pulse →						
☐	Respiration→						
☐	Sugar Monitoring →						

The CRCF nurse must write a detailed nurse's note/summary every 3 months including: height, weight, vital signs, functional/cognitive dependencies, any behavioral problems and any medical complications following face to face interaction.

Progress Note(s) – Please date and initial each note.

Individual Care Plans (ICP)

- Must be in each resident's file/chart.
- Must be reviewed and updated every six (6) months. "No changes" is an unacceptable update.
- All ICPs/six (6) month review must be reviewed, updated, signed and dated by the CRCF nurse.
- Must be signed by the administrator, resident, or the responsible party/sponsoring agency. If the resident is unable to sign, then an explanation must be written on the ICP.
- Must be reflective of the resident's service category (OSCAP, OSS, Hospice, waiver) and current condition.
- Redeveloped at least every 24 months from the date of the initial ICP.

Individual Care Plans (ICP)

INDIVIDUAL CARE PLAN (ICP)

Resident Name _____ Date of Admission_____

Diagnosis: _____

Advanced Directives: YES ___NO ___ Power of Attorney: YES ___ NO ___ Responsible Party: _____

Primary Physician: _____ Dietary Requirements: _____

Transportation Arrangement for Visits to Physician(s): Family: _____ Facility: _____ Other: _____

TASK / NEED	HOW MUCH ASSISTANCE	FREQUENCY	GOAL/ ACHIEVEMENT DATE	RESPONSIBLE PARTY
DRESSING	___Independent ___Needs Reminders/cues ___Lay out articles ___Full Assistant Needed ___Frequent clothing changes ___Minor Assist (e.g., buttons, laces, zippers, etc)	___Daily ___AM ___PM ___As Needed ___As Requested ___Other (explain)	____ Next 6 months ____ Other (explain) To assure that the resident is appropriately dressed	___Self ___Staff caregiver ___Family/Sponsor ___Other
BATHING				

Individual Care Plans (ICP)

TASK / NEED	HOW MUCH ASSISTANCE	FREQUENCY	GOAL/ ACHIEVEMENT DATE	
AMBULATION / TRANSFER	___Independent in walking ___Supervision ___Hands on assist ___Uses walker/ cane ___Uses wheelchair to ambulate ___Needs assistance transferring	___Daily ___As Needed	____ Next 6 months ____ Other (explain) To avoid falls	___Self ___Staff caregiv ___Family/Spor ___Other
BEHAVIOR / MENTAL STATUS	___Alert and oriented ___Elopement risk ___Aggression (physical/verbal) ___Uncooperative ___Confused / disoriented	___Daily ___Other (explain)	____ Next 6 months ____ Other (explain) To assure appropriate behavior	___Self ___Staff caregiv ___Family/Spor ___Other
ACTIVITIES	___Exercise ___Bible Study ___Bingo ___Singing ___Movies ___Outings ___Pet Therapy ___Church Service ___Crafts ___Puzzles ___TV ___Other		____ Next 6 months ____ Other (explain) Encourage participation	___Self ___Staff caregiv ___Family/Spor ___Other
OTHER				

Resident Signature John C. Resident _____ Date: _____

Responsible Party/Sponsor _____ [ ] Family chose not to participate

Facility Representative Janie Administrator / Nurse Betty, RN - DATE

Sent letter on _____(copy attached) or Called on _____ & spoke with _____

Individual Care Plans (ICP)

INDIVIDUAL CARE PLAN REVIEW

[ ] Six (6) Month Review **[ ] Change in Need**

Comments:

"No changes" is not an acceptable update.

Resident Signature John C. Resident Date: DATE

Responsible Party/Sponsor _____

Facility Representative Janie Administrator / Nurse Betty, RN - DATE

Sent letter on _____ or Called on _____ & spoke with_____

CRCF Nurse Duties

- OSCAP approved facilities are require to employ or contract with a licensed nurse (either a Licensed Practical Nurse or and Registered Nurse).
- The ICP must be reviewed, revised or updated, signed and dated by the nurse every at least every six (6) months.
- The initial Monthly Task Log must be created by the CRCF nurse. The CRCF nurse must review, sign and date all Monthly Task Logs at least every 90 days. Revisions to the Monthly Task Logs must be made by the CRCF Nurse as needed. The Nurse must sign and date the Monthly Task Logs when revisions/updates are made.

CRCF Nurse Duties

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

OSCAP and Hospice Services

- Beneficiaries of Hospice and OSCAP may only receive personal care through one service or the other; therefore, they must choose either Hospice or OSCAP.

- An OSCAP participant residing in a CRCF has the right to choose which service they receive.

SOUTH CAROLINA Healthy Connections MEDICAID

OSCAP Provider Requirements

- Licensure in good standing by the South Carolina Department of Health and Environmental Control (SCDHEC)
- OSS Participation Agreement
- Facility documentation of resident funds and PNA
- Facility notification to the SCDHHS and MCCS of admissions, discharges, transfers, and deaths within 72 hours
- Monthly processing of the OSS payments
- Meet specific basic requirements of the Americans with Disabilities Act (ADA) including wheelchair accessibility
- Have a minimum of six (6) hours relevant in-service training per calendar year, in addition to SCDHEC required training

- Must designate, in writing, a licensed full time facility administrator and an administrator's designee
- Must notify SCDHHS within 10 business days in the event of a change in the administrator, OSCAP nurse, address, phone number, or an extended absence of the administrator
- Ensure the nurse is in good standing with the South Carolina Board of Nursing
- Ensure that resident to staff ratios are consistent with SCDHEC regulation at all times
- The facility must not be without nursing coverage for more than 90 days

Questions……..

- How are OSCAP services documented?

- How often must the CRCF nurse review, sign and date all Monthly Task Logs ?

OSS & OSCAP Billing & Payment

Rates for 2017

OSS and OSCAP Rates

OSS Rate : $1,420

PNA: $67

Facility Payment: $ 1,353 per month

OSCAP Rate: $1,627

PNA: $67

Facility Payment: $1,560 per month

Date of Service	Payment Date
January 2017	March 03, 2017
February 2017	April 7,2017
March 2017	May 5, 2017
April 2017	June 2, 2017
May 2017	July 7, 2017
June 2017	August 4, 2017
July 2017	September 1, 2017
August 2017	October 6, 2017
September 2017	November 3, 2017
October 2017	December 1, 2017
November 2017	January 5, 2018
December 2017	February 2, 2018

Personal Needs Allowance

- OSS beneficiaries who receive recurring income of SSI only are allowed to keep $67 per month for personal needs.
- Eligible beneficiaries who have income other than SSI are allowed to keep an extra $20 for personal needs, bringing their total to $87.
- PNA increases by $2 each year, if there is a COLA.
- Please refer to the CRCF-01 for each beneficiary to determine their PNA amount.

TAD Reminders

- Changes to the TAD, MUST be submitted with a CRCF-01 Form to support the action made on the TAD.
- OSS providers have **13 months** from the date of the signed CRCF-01 Form to submit the form for billing. Any forms past the 13 month timeframe may not be processed.
- Failure to submit a CRCF-01 Form could result in delayed payment.
- **Don't send CRCF-01 form in with TAD until you have completed the form from eligibility with effective date, recurring income, PNA amount, signature and date.**
- Please verify the mailing address on the TAD to ensure the address is correct. If the address is incorrect, please contact Terrell McMorris at Terrell.McMorris@scdhhs.gov with the correct information.

TAD Mailing Address

Claims Receipt – CRCF

Claims Section

Post Office Box 67

Columbia, SC 29202-0067

All TADs and signed CRCF-01 Forms, to include termination forms, must be sent to the address above. If your facility has not received a TAD by the second Friday in the month, you will need to contact the Provider Service Center. Please remember to submit your TAD no later than 17th of each month.
PSC-888-289-0709 option 3

Daily Census

- This component includes documenting the daily census of all residents, regardless of pay source. The documentation must include identifiers for Medicaid participants and specify whether the participant was on medical or non-medical bed hold, admitted or discharged on that date, or was transported for emergency treatment.

Questions

- Where does the resident's personal needs allowance come from?

- What form(s) is used to communicate an OSS beneficiary's status in your facility?

OSS Quality Assurance

SOUTH CAROLINA
Healthy Connections
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SCDHHS OSS QA Reminders

- Providers must meet licensing requirements as outlined in the South Carolina Department of Health and Environmental Control Regulation 61-84.

- Providers must meet all requirements as outlined in the South Carolina Department of Health and Human Services Optional State Supplementation Manual.

https://www.scdhhs.gov/provider-type/optional-state-supplementation-021505-edition-posted-020205

Business License

- Every city in South Carolina requires for businesses operating in the city to obtain a business license.

  (There may be some exception for non-profits).

- County requirements vary.

- If your facility does not maintain a business license, please inquire if one is required (and obtain if appropriate).

Questions…

- According to SCDHHS policy, how often must employee background checks be completed?

- Who cannot be hired?

- Background checks are required for all employees prior to employment then at least every 5 years thereafter.

-Cannot hire or have employed anyone who has a felony conviction within the last 10 years.

-Stipulations for potential employees or employees with misdemeanor convictions are outlined in your Optional State Supplementation Provider Manual (Section 2, page 18).

Working Capital

- Working capital is the funds available for the operations of a business. It allows the Community Residential Care Facility to perform its day-to-day activities and meet its functional requirements. (Optional State Supplementation Provider Manual Section 2, page 15).

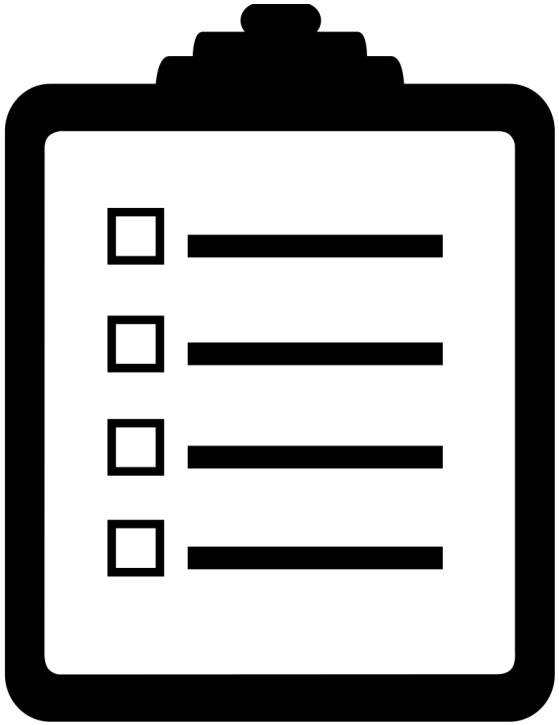
The minimum working capital levels are:

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

A statement from your financial institution will be required noting the minimum average balance maintained in the account.

Questions…

- For a new admission, how long does the facility have to complete an initial assessment?
  - Initial Individual Care Plan?



SCDHEC Regulation 61-84

-Based on provider reviews, Individual Care Plans are being completed prior to the initial assessment.

- 702. Assessment (II). A written assessment of the resident in accordance with Section 101.H shall be conducted by a direct care staff member as evidenced by his or her signature and date within a time-period determined by the facility, but no later than 72 hours after admission.

- 703. Individual Care Plan (II). A. Using the written assessment, the facility shall develop within seven (7) days of admission an ICP with participation of the resident, administrator (or designee), and/or the sponsor or responsible party when appropriate, as evidenced by their signatures and date. The ICP shall be reviewed and/or revised as changes in resident needs occur, but not less than semi-annually with the resident, administrator (or designee), and/or the sponsor or responsible party as evidenced by their signatures and date.

Personal Needs Allowance

- Specified in the Optional State Supplementation Provider Manual, Section 2, page 3 and in the SCDHEC Regulation 61-84, Section 902.

1-Signed and dated agreement from the beneficiary allowing the facility to manage his/her personal needs allowance.

2-The beneficiary must sign upon receiving personal needs allowance or prior to any purchase made on behalf of the resident. The date of the transaction must be present as well as the cash amount. If the beneficiary is unable to sign, the facility must have a policy in place regarding confirming personal needs allowance was given to the beneficiary.

3-Maintain receipts for all purchases made on behalf of the beneficiary.

4-Provide a quarterly report of the account balance to the beneficiary.

Personal Needs Allowance

- Why is the allowance documentation necessary?

Financial exploitation and embezzlement are a serious matter.

Allegations of embezzlement are referred to the Attorney General's Medicaid Fraud Control Unit.

http://www.scag.gov/medicaid-fraud

Personal Needs Allowance Documentation Example

Personal Needs Allowance					
Date	Received	Withdrawal	Notes	Balance	Signature
1/1/2017	$87.00	$87.00	cash to resident	$0.00	John Doe
2/1/2017	$87.00	$25.00	cash to resident	$62.00	John Doe
2/15/2017	$0.00	$10.00	XYZ Pharmacy	$52.00	John Doe
2/20/2017	$0.00	$15.00	Bobs Barber Shop	$37.00	John Doe
3/1/2017	$87.00	$25.00	cash to resident	$99.00	John Doe
I authorize XYZ CRCF Administrator to maintain my personal needs allowance.				John Doe 12/15/2016	
XYZ Administrator-		Jane Smith 12/15/2016			
* Signatures are to be original					

Billing Inaccuracies

- One provider owning multiple facilities moving residents from facility to facility but not completing appropriate forms for termination and transfer. This often causes payments to the facility in which the resident was not present. Payments must go to the provider of service (where the resident was residing). Even if this will be partial months to multiple facilities.
- Instances where the facility goes through a change of ownership that has not been approved by SCDHHS which results in a sharing of OSS/OSCAP payments with a non-enrolled SCDHHS facility will be referred to SCDHHS Division of Program Integrity and/or the Medicaid Fraud Control Unit of the SC Attorney General's Office.

Question…

- Can a facility continue to receive payments for OSCAP services if the resident is not present at the facility (bed hold)?

Reimbursement for OSCAP services is not allowed for any absence from the CRCF; payment reverts to the OSS rate for any days the resident is away from the facility. (Optional State Supplementation Provider Manual Section 2, page 6).

OSCAP Provider Responsibilities

- The CRCF must maintain liability insurance to protect all paid and volunteer staff, including board members, from liability incurred while acting on behalf of the CRCF during the life of the OSCAP contract. The CRCF must furnish a copy of the insurance policy to SCDHHS upon request. (Optional State Supplementation Provider Manual Section 2, page 17).

- Providers must maintain a section in its existing policy and procedure manual describing the provision of OSCAP services. (Optional State Supplementation Provider Manual, Section 2, pages 28-30).

  -The OSCAP section of the facility's policy and procedure manual must be descriptive. Printing the pages out of the Optional State Supplementation Provider Manual and placing in the facility's policy and procedure manual will not be accepted.

Incontinence Supplies

- Incontinence Supplies (IS) referrals are made to SCDHHS. The referral is processed to determine if the participant meets the criteria for receiving the service(s). This includes a telephone assessment to determine whether the appropriate medical necessity criteria are met.

Incontinence Supplies

Provider Choice Forms (PCF)	Physician Certificate
• CRCFs must discuss the provider choices with residents in their facility and let residents select the five (5) providers they would like to deliver their IS. • The PCF Form must be returned to SCDHHS.	• Effective July 1, 2014, Incontinence Supply providers will be responsible for obtaining the Physician Certification of Incontinence SCDHHS Form 168IS prior to delivering IS.

Service Contact: Shanese Mathis - 803-898-9454

Bed Locator

http://www.nfbl.sc.gov/

Bed Locator

If you are looking for a facility that accepts residents/patients please visit the Nursing Home Bed Locator website at www.nfbl.sc.gov

- ALL OSS providers must update their bed availability information at a minimum of ONCE PER MONTH at the South Carolina Long Term Care Bed Locator website www.nfbl.sc.gov.
- Failure to report in a timely manner could result in sanctions against the facility.

Bed Locator: Steps

- All licensed CRCFs are listed on the South Carolina Long Term Care Bed Locator website. To update your facility information please follow the steps listed below:
- In order to create an account, users must go to the top right corner of the webpage and press the **login** button, which will take users to another page.
- On the new page, **click on the blue hyperlink that says Register Here**. This will take users to a new page where they can choose a user name, password of at least eight (8) characters, and their email address.
- Under User Comments, users should enter the facility or facilities that they want to be associated with. Please note that in order to register, users **MUST have an email address**.

Questions

Healthy Connections