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CHAPTER 6.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

ARTICLE 1.

GENERAL PROVISIONS

**SECTION 44‑6‑5.** Definitions.

As used in this chapter:

(1) “Department” means the State Department of Health and Human Services.

(2) “Division” means the Division of Research and Statistical Services of the State Budget and Control Board.

(3) “Costs of medical education” means the direct and indirect teaching costs as defined under Medicare.

(4) “Market basket index” means the index used by the federal government on January 1, 1986, to measure the inflation in hospital input prices for Medicare reimbursement. If that measure ceases to be calculated in the same manner, the market basket index must be developed and regulations must be promulgated by the commission using substantially the same methodology as the federal market basket uses on January 1, 1986. Prior to submitting the regulations concerning the index to the General Assembly for approval pursuant to the Administrative Procedures Act, the department shall submit them to the Health Care Planning and Oversight Committee for review.

(5) “Medically indigent” means:

(a) all persons whose gross family income and size falls at or below the federal Community Service Administration guidelines and who meet certain qualifying criteria regarding real property allowance, qualifying services, residency requirements, and other sponsorship, and migrant or seasonal farm workers who have no established domicile in any state; and

(b) all persons whose gross family income and size falls between one hundred percent and two hundred percent of the Community Service Administration guidelines who meet certain other qualifying criteria regarding real property allowance, qualifying services, residency requirements, and other sponsorship and whose medical bill is sufficiently large in relation to their income and resources to preclude full payment. For the purposes of this definition, the qualifying criteria for real property allowance shall permit ownership of up to fifty acres of farmland upon which the family has resided for at least twenty‑five years.

(6) “Net inpatient charges” means the total gross inpatient charges, minus the unreimbursed cost of medical education and the unreimbursed cost of providing medical care to medically indigent persons. The cost of care provided by a hospital to meet its Hill‑Burton obligation is not considered an unreimbursed cost of providing medical care to medically indigent persons.

(7) “South Carolina growth index” means the percentage points added to the market basket index to adjust for the South Carolina specific experience. The Health Care Planning and Oversight Committee shall complete a study which identifies and quantifies those elements which should be included in the growth index. The elements may include, but are not limited to: population increases, aging of the population, changes in the type and intensity of hospital services, technological advances, the cost of hospital care in South Carolina relative to the rest of the nation, and needed improvements in the health status of state residents. Based on the study, the department shall develop and promulgate regulations for the annual computation of the growth index. Prior to submitting the regulations concerning the index to the General Assembly for approval pursuant to the Administrative Procedures Act, the department shall submit them to the Health Care Planning and Oversight Committee for review. Until a formula for computing the South Carolina growth index is promulgated, the annual index must be six and six‑tenths percent which is equal to the average percentage difference between South Carolina hospital expenditures and the federal market basket index for the previous ten years.

(8) “State resident” means a person who is domiciled in South Carolina. A domicile once established is lost or changes only when one moves to a new locality with the intention of abandoning his old domicile and intends to live permanently or indefinitely in the new locale.

(9) “Target rate of increase” means the federal market basket index as modified by the South Carolina growth index.

(10) “General hospital” means any hospital licensed as a general hospital by the Department of Health and Environmental Control.

**SECTION 44‑6‑10.** Creation of commission; members; term; conflict of interests.

There is created the State Department of Health and Human Services which shall be headed by a Director appointed by the Governor, upon the advice and consent of the Senate. The director is subject to removal by the Governor pursuant to the provisions of Section 1‑3‑240.

**SECTION 44‑6‑30.** Duties and limitations.

The department shall:

(1) administer Title XIX of the Social Security Act (Medicaid), including the Early Periodic Screening, Diagnostic and Treatment Program, and the Community Long‑Term Care System;

(2) be designated as the South Carolina Center for Health Statistics to operate the Cooperative Health Statistics Program pursuant to the Public Health Services Act;

(3) be prohibited from engaging in the delivery of services.

**SECTION 44‑6‑40.** Duties.

For all health and human services interagency programs provided for in this chapter, the department shall have the following duties:

(1) Prepare and approve state and federal plans prior to submission to the appropriate authority as required by law for final approval or for state or federal funding, or both.

Such plans shall be guided by the goal of delivering services to citizens and administering plans in the most effective and efficient ways possible.

(2) Compile and maintain in a unified, concise, and orderly form information concerning programs provided for in this chapter.

(3) Continuously review and evaluate programs to determine the extent to which they:

(a) meet fiscal, administrative, and program objectives; and

(b) are being operated cost effectively.

(4) Evaluate plans and programs in terms of their compatibility with state objectives and priorities giving specific attention to areas outlined in Section 44‑6‑70.

(5) Formulate for consideration and promulgation criteria, standards, and procedures that ensure assigned programs are administered effectively, equitably, and economically and in accordance with statewide policies and priorities.

(6) Inform the Governor and the General Assembly as to the effectiveness of the criteria, standards, and procedures promulgated pursuant to item (5) of this section.

(7) Develop in conjunction with other state agencies an information system to provide data on comparative client and fiscal information needed for programs.

(8) Develop a mechanism for local planning.

(9) Obtain from participating state agencies information considered necessary by the department to perform duties assigned to the department.

**SECTION 44‑6‑45.** Authority of commission to collect administrative fees associated with accounts receivable for those individuals or entities which negotiate repayment to agency.

The State Department of Health and Human Services may collect administrative fees associated with accounts receivable for those individuals or entities which negotiate repayment to the agency. The administrative fee may not exceed one and one‑half percent of the amounts negotiated and must be remitted to the State Treasurer and deposited to the credit of the general fund of the State.

**SECTION 44‑6‑50.** Contracts with other agencies; program monitoring.

In carrying out the duties provided for in Section 44‑6‑30 the department shall:

(1) Contract for health and human services eligibility determination with performance standards regarding quality control as required by law or regulation.

(2) Contract for operation of certified Medicaid management information claims processing system. For the first year of its operation it shall contract for such system with the Department of Social Services.

(3) Contract for other operational components of programs administered under this chapter as considered appropriate.

(4) Monitor and evaluate all contractual services authorized pursuant to this chapter to assure effective performance. Any contract entered into under the provisions of this chapter must be in accordance with the provisions of the South Carolina Consolidated Procurement Code.

(5) Establish a procedure whereby inquiries from members of the General Assembly concerning the department’s work and responsibility shall be answered as expeditiously and definitely as possible.

**SECTION 44‑6‑70.** Preparation of state plan and resource allocation recommendations.

A state plan must be prepared by the department for each program assigned to it and the department must also prepare resource allocation recommendations based on such plans. The resource allocation recommendations must be approved pursuant to state and federal law. The state plans must address state policy and priority areas of service with specific attention to the following objectives:

(a) Prevention measures as addressed in health and human services programs.

(b) Achievement of a balanced health care delivery system assuring that regulations, coverage, and reimbursement policies assure that while the most appropriate care is given, tailored to the client’s needs, it is delivered in the most cost‑effective manner.

(c) Simplification of paperwork requirements.

(d) Achievement of optimum cost effectiveness in administration and delivery of services provided quality of care is assured.

(e) Improvement of effectiveness of third party reimbursement efforts.

(f) Assurance of maximum utilization of private and nonprofit providers in administration and service delivery systems, provided quality of care is assured.

(g) Encouragement of structured volunteer programs in administration and service delivery.

**SECTION 44‑6‑80.** Annual and interim reports.

The department must submit to the Governor, the State Budget and Control Board, and the General Assembly an annual report concerning the work of the department including details on improvements in the cost effectiveness achieved since the enactment of this chapter and must recommend changes for further improvements.

Interim reports must be submitted as needed to advise the Governor and the General Assembly of substantive issues.

**SECTION 44‑6‑90.** Promulgation of regulations; other agencies to cooperate with Commission.

The department may promulgate regulations to carry out its duties.

All state and local agencies whose responsibilities include administration or delivery of services which are covered by this chapter shall cooperate with the department and comply with its regulations.

**SECTION 44‑6‑100.** Personnel of Commission; duties; compensation.

The department employees shall have such general duties and receive such compensation as determined by the director. The director shall be responsible for administration of state personnel policies and general department personnel policies. The director shall have sole authority to employ and discharge employees subject to such personnel policies and funding available for that purpose.

In all instances, the director shall serve as the chief administrative officer of the department and shall have the responsibility of executing policies, directives, and actions of the department either personally or by issuing appropriate directives to the employees.

The goal of the provisions of this section is to ensure that the department’s business is conducted according to sound administrative practice, without unnecessary interference with its internal affairs. Public officers and employees shall be guided by this goal and comply with these provisions.

ARTICLE 2.

MEDICALLY INDIGENT ASSISTANCE ACT

**SECTION 44‑6‑132.** Legislative findings and intent.

The General Assembly finds that:

(1) There are citizens who cannot afford to pay for hospital care because of inadequate financial resources or catastrophic medical expenses.

(2) Rising health care costs and the growth of the medically indigent population have increased the strains on the health care system with a growing burden on the hospital industry, health insurance companies, and paying patients.

(3) This burden has affected businesses, which are large purchasers of health care services through employee insurance benefits, and taxpayers in counties which support public hospitals, and it causes the cost of services provided to paying patients to increase in a manner unrelated to the actual cost of services delivered to them.

(4) Hospitals which provide the bulk of unreimbursed services cannot compete economically with hospitals which provide relatively little care to indigent persons.

(5) Because of the complexity of the health care system, any effort to resolve the problem of paying for care for medically indigent persons must be multifaceted and shall include at least four general principles:

(a) Funds must be made available to assure continued access to quality health care for medically indigent patients.

(b) Cost containment measures and competitive incentives must be placed into the health care system along with the additional funds.

(c) The cost of providing indigent care must be equitably borne by the State, the counties, and the providers of care.

(d) State residents must be guaranteed access to emergency medical care regardless of their ability to pay or county of residence.

It is the intent of the General Assembly to:

(1) assure care for the largest possible number of its medically indigent citizens within funds available by:

(a) expanding the number of persons eligible for Medicaid services, using additional state and county funds to take advantage of matching federal funds;

(b) creating a fund based on provider and local government contributions to provide medical assistance to those citizens who do not qualify for Medicaid or any other government assistance and who do not have the means to pay for hospital care; and

(c) mandating access to emergency medical care for all state residents in need of the care;

(2) Provide incentives for cost containment to providers of care to indigent patients by implementing a prospective payment system in the Medicaid and Medically Indigent Assistance Fund programs;

(3) monitor efforts to foster competition in the health care market place while being prepared to make adjustments in the system through regulatory intervention if needed;

(4) promote market reforms, as the single largest employer in the State, by structuring its health insurance program to encourage healthy lifestyles and prudent use of medical services; and

(5) reduce where possible or maintain the current rate schedules of hospitals to keep costs from escalating.

**SECTION 44‑6‑135.** Short title.

The following sections shall be known and may be cited as the “South Carolina Medically Indigent Assistance Act”.

**SECTION 44‑6‑140.** Medicaid hospital prospective payment system; cost containment measures.

(A) To provide cost containment incentives for providers of care to Medicaid recipients, the department shall convert the Medicaid hospital reimbursement system from a retrospective payment system to a prospective payment system by October 1, 1985. The prospective payment system includes, at a minimum, the following elements:

(1) a maximum allowable payment amount established for individual hospital products, services, patient diagnoses, patient day, patient admission, or per patient, or any combination thereof. This payment must be based on hospital costs rather than hospital charges and must be adjusted at least every two years to reflect the most recent audited cost data available. The department shall set by regulation those circumstances under which a hospital may seek an exception. The maximum allowable payment amount must be weighted to allow for the costs of medical education and primary, secondary, or tertiary care considerations;

(2) payment on a timely basis to the hospital by the commission or patient or both, of the maximum allowable payment amount determined by the commission; and

(3) acceptance by the hospital of the maximum payment amount as payment in full, which includes any deductible or copayment provided for in the state Medicaid program.

(B) The department shall at the same time implement other cost containment measures which include, but are not limited to:

(1) utilization reviews for appropriateness of treatment and length of stay;

(2) preadmission certification of nonemergency admissions;

(3) mandatory outpatient surgery in appropriate cases;

(4) a second surgical opinion pilot study; and

(5) procedures for encouraging the use of outpatient services.

The department, to the fullest extent possible, shall utilize information required in this subsection in the form hospitals are presently submitting the information to other governmental agencies or in the form hospitals are presently utilizing the information within the hospital.

**SECTION 44‑6‑146.** County assessments for indigent medical care; penalties for failure to pay assessments in timely manner.

(A) Every fiscal year the State Treasurer shall withhold from the portion of the Local Government Fund allotted to the counties a sum equal to fifty cents per capita based on the population of the several counties as shown by the latest official census of the United States. The money withheld by the State Treasurer must be placed to the credit of the commission and used to provide Title XIX (Medicaid) services.

(B) County governments are assessed an additional thirteen million dollars annually for use as matching funds for Medicaid services. Of these funds, seven and a half million dollars must be deposited into the Medicaid Expansion Fund created by Section 44‑6‑155.

The department shall assess each county its share of the thirteen million dollars based on a formula which equally weighs the following factors in each county: property value, personal income, net taxable sales, and the previous two years of claims against the medically indigent assistance fund or program against county residents. If a trust fund has been established in a county to fund indigent care in the county, contributions on behalf of the county must be credited against the county assessment.

(C) Within thirty days of the first day of the state’s fiscal year, and on the first day of the other three quarters, each county shall remit one‑fourth of its total assessment to the department. The department shall allow a brief grace period during which late payments are not subject to interest or penalty.

Any county which fails to pay its assessment within the time allotted must pay, in addition to the assessment, a penalty of five percent of the assessment and interest at one and one‑half percent per month from the date the assessment was originally due to the date of the payment of the assessment and penalty. The department may in its discretion waive or reduce the penalty or interest or any part thereof.

**SECTION 44‑6‑150.** Medically Indigent Assistance Program; reporting of charges for sponsored patients; duties of commission; duty to provide unreimbursed medical care to indigent persons.

(A) There is created the South Carolina Medically Indigent Assistance Program administered by the department. The program is authorized to sponsor inpatient hospital care for which hospitals shall receive no reimbursement. A general hospital equipped to provide the necessary treatment shall:

(1) admit a patient sponsored by the program; and

(2) accept the transfer of a patient sponsored by the program from a hospital which is not equipped to provide the necessary treatment.

In addition to or in lieu of an action taken affecting the license of the hospital, when it is established that an officer, employee, or member of the hospital medical staff has violated this section, the South Carolina Department of Health and Environmental Control shall require the hospital to pay a civil penalty of up to ten thousand dollars.

(B) Hospital charges for patients sponsored by the Medically Indigent Assistance Program must be reported to the Division of Research and Statistical Services pursuant to Section 44‑6‑170.

(C) In administering the Medically Indigent Assistance Program, the department shall determine:

(1) the method of administration including the specific procedures and materials to be used statewide in determining eligibility for the program;

(a) In a nonemergency, the patient shall submit the necessary documentation to the patient’s county of residence or its designee to determine eligibility before admission to the hospital.

(b) In an emergency, the hospital shall admit the patient pursuant to Section 44‑7‑260. If a hospital holds the patient financially responsible for all or a portion of the inpatient hospital bill, and if the hospital determines that the patient could be eligible for the program, it shall forward the necessary documentation along with the patient’s bill and other supporting information to the patient’s county of residence or its designee for processing. A county may request that all hospital bills incurred by its residents sponsored by the program be submitted to the county or its designee for review.

(2) the population to be served, including eligibility criteria based on family income and resources. Eligibility is determined on an episodic basis for a given spell of illness. Eligibility criteria must be uniform statewide and may include only those persons who meet the program’s definition of medically indigent;

(3) the health care services covered;

(4) a process by which an eligibility determination can be contested and appealed; and

(5) the program may not sponsor a patient until all other means of paying for or providing services have been exhausted. This includes Medicaid, Medicare, health insurance, employee benefit plans, or other persons or agencies required by law to provide medical care for the person. Hospitals may require eligible patients whose gross family income is between one hundred percent and two hundred percent of the federal poverty guidelines, to make a copayment based on a sliding payment scale developed by the department based on income and family size.

(D) Nothing in this section may be construed as relieving hospitals of their Hill‑Burton obligation to provide unreimbursed medical care to indigent persons.

**SECTION 44‑6‑155.** Medicaid Expansion Fund.

(A) There is created the Medicaid Expansion Fund into which must be deposited funds:

(1) collected pursuant to Section 44‑6‑146;

(2) collected pursuant to Section 12‑23‑810; and

(3) appropriated pursuant to subsection (B).

This fund must be separate and distinct from the general fund. These funds are supplementary and may not be used to replace general funds appropriated by the General Assembly or other funds used to support Medicaid. These funds and the programs specified in subsection (C) are exempt from any budgetary cuts, reductions, or eliminations caused by the lack of general fund revenues. Earnings on investments from this fund must remain part of the separate fund and must not be deposited in the general fund.

(B) The department shall estimate the amount of federal matching funds which will be spent in the State during the next fiscal year due to the changes in Medicaid authorized by subsection (C). Based on this estimate, the General Assembly shall appropriate to the Medicaid Expansion Fund state funds equal to the additional state revenue generated by the expenditure of these federal funds.

(C) Monies in the fund must be used to:

(1) provide Medicaid coverage to pregnant women and infants with family incomes above one hundred percent but below one hundred eighty‑five percent of the federal poverty guidelines;

(2) provide Medicaid coverage to children aged one through six with family income below federal poverty guidelines;

(3) provide Medicaid coverage to aged and disabled persons with family income below federal poverty guidelines;

(4) [reserved];

(5) [reserved];

(6) [reserved];

(7) provide up to two hundred forty thousand dollars to reimburse the Office of Research and Statistics of the State Budget and Control Board and hospitals for the cost of collecting and reporting data pursuant to Section 44‑6‑170;

(8) [reserved].

(D) Any funds not expended for the purposes specified in subsection (C) during a given year are carried forward to the succeeding year for the same purposes.

**SECTION 44‑6‑160.** Target rate of increase for net inpatient charges; excessive increases; penalties.

(A) By August first of each year, the department shall compute and publish the annual target rate of increase for net inpatient charges for all general hospitals in the State. The target rate of increase will be established for a twelve‑month period from October first through September thirtieth of the following year. Once established, the target rate of increase must not be amended during the year except as provided in subsection (B) of this section. The department shall monitor the performance of the hospital industry to contain costs, specifically as evidenced by the annual rate of growth of net inpatient charges. If the department determines that the annual rate of increase in net inpatient charges for the hospital industry has exceeded the target rate of increase established for that year, the department shall appoint an expert panel for the purpose of analyzing the financial reports of each hospital whose net inpatient charges exceeded the target rate of increase. The panel’s review shall take into consideration service volume, intensity of care, and new services or facilities. The panel shall consist of at least three members who have broad experience, training, and education in the field of health economics or health care finance. The panel shall report its findings and recommendations, including recommended penalties or sanctions, to the department. The department shall decide what, if any, penalty it will impose within three months of receiving all necessary data.

(B) The department may impose penalties or sanctions it considers appropriate. Penalties must be prospective. Financial penalties are limited to a reduction in a hospital’s target rate of increase for the following year. Any reduction in a hospital’s target rate of increase for the next year must not be greater than the amount the hospital exceeded the industry’s target rate of increase for the previous year. Once a hospital is sanctioned, it must be reviewed annually until it succeeds in remaining below its target rate of increase.

**SECTION 44‑6‑170.** Collection and release of health care related data; confidentiality; regulations to be promulgated; Data Oversight Council; Health Data Analysis Task Force; hospitals to provide required information; violations and penalties.

(A) As used in this section:

(1) “Office” means the Office of Research and Statistics of the Budget and Control Board.

(2) “Council” means the Data Oversight Council.

(3) “Committee” means the Joint Legislative Health Care Planning and Oversight Committee.

(B) There is established the Data Oversight Council comprised of:

(1) one hospital administrator;

(2) the chief executive officer or designee of the South Carolina Hospital Association;

(3) one physician;

(4) the chief executive officer or designee of the South Carolina Medical Association;

(5) one representative of major third party health care payers;

(6) one representative of the managed health care industry;

(7) one nursing home administrator;

(8) three representatives of nonhealth care‑related businesses;

(9) one representative of a nonhealth care‑related business of less than one hundred employees;

(10) the executive vice president or designee of the South Carolina Chamber of Commerce;

(11) a member of the Governor’s office staff;

(12) a representative from the Human Services Coordinating Council;

(13) the director or his designee of the South Carolina Department of Health and Environmental Control;

(14) the executive director or his designee of the State Department of Health and Human Services;

(15) the chairman or his designee of the State Health Planning Committee created pursuant to Section 44‑7‑180.

The members enumerated in items (1) through (10) must be appointed by the Governor for three‑year terms and until their successors are appointed and qualify; the remaining members serve ex officio. The Governor shall appoint one of the members to serve as chairman. The office shall provide staff assistance to the council.

(C) The duties of the council are to:

(1) make periodic recommendations to the committee and the General Assembly concerning the collection and release of health care‑related data by the State which the council considers necessary to assist in the formation of health care policy in the State;

(2) convene expert panels as necessary to assist in developing recommendations for the collection and release of health care‑related data;

(3) approve all regulations for the collection and release of health care‑related data to be promulgated by the office;

(4) approve release of health care‑related data consistent with regulations promulgated by the office;

(5) recommend to the office appropriate dissemination of health care‑related data reports, training of personnel, and use of health care‑related data.

(D) The office, with the approval of the council, shall promulgate regulations in accordance with the Administrative Procedures Act regarding the collection of inpatient and outpatient information. No data may be released by the office except in a format recommended by the council and consistent with regulations. Before the office releases provider identifiable data the office must determine that the data to be released is for purposes consistent with the regulations as promulgated by the office and the release must be approved by the council and the committee. Provided, however, committee approval of the release is not necessary if the data elements and format in the release are substantially similar to releases or standardized reports previously approved by the committee. The council shall make periodic recommendations to the committee and the General Assembly concerning the collection and release of health care‑related data by the State. Regulations promulgated by the office mandating the collection of inpatient or outpatient data apply to every provider or insurer affected by the regulation regardless of how the data is collected by the provider or insurer. Every effort must be made to utilize existing data sources.

(E) Information may be required to be produced only with respect to admissions of and treatment to patients after the effective date of the regulations implementing this section, except that data with respect to the medical history of the patient reasonably necessary to evaluation of the admission of and treatment to the patient may be required.

(F) The office shall convene a Health Data Analysis Task Force composed of technical representatives of universities and other private sector and public agencies including, but not limited to, health care providers and insurers to make recommendations to the council concerning types of analyses needed to carry out this section.

(G) All general acute care hospitals and specialized hospitals including, but not limited to, psychiatric hospitals, alcohol and substance abuse hospitals, and rehabilitation hospitals shall provide inpatient and financial information to the office as set forth in regulations.

All hospital‑based and freestanding ambulatory surgical facilities as defined in Section 44‑7‑130, hospital emergency rooms licensed under Chapter 7, Article 3, and any health care setting which provides on an outpatient basis radiation therapy, cardiac catherizations, lithotripsy, magnetic resonance imaging, and positron emission therapy shall provide outpatient information to the office as set forth in the regulation. Other providers offering services with equipment requiring a Certificate of Need shall provide outpatient information to the office. Additionally, licensed home health agencies shall provide outpatient information to the office as set forth in the regulation.

Release must be made no less than semiannually of the patient medical record information specified in regulation to the submitting hospital and other information specified in regulation to the hospital’s designee. However, the hospital’s designee must not have access to patient identifiable data.

(H) If a provider fails to submit the health care data as required by this section or Section 44‑6‑175 or regulations promulgated pursuant to those sections, the Office of Research and Statistics may assess a civil fine of up to five thousand dollars for each violation, but the total fine may not exceed ten thousand dollars.

(I) A person, as defined in Section 44‑7‑130, seeking to collect health care data or information for a registry shall coordinate with the office to utilize existing data collection formats as provided for by the office and consistent with regulations promulgated by the office. With the exception of information that may be obtained from the Office of Vital Records, Department of Health and Environmental Control, in accordance with Section 44‑63‑20 and Regulation 61‑19 and disease information required to be reported to the Department of Health and Environmental Control under Sections 44‑29‑10, 44‑29‑70, and 44‑31‑10 and Regulations 61‑20 and 61‑21 and notwithstanding any other provision of law, no hospital or health care facility or health care professional required by this section to submit health care data is required to submit data to a registry which has not complied with this section.

**SECTION 44‑6‑175.** Annual reports to be provided to Division of Research and Statistical Services.

(A) Annually, when a hospital submits its Medicare Cost Report to the Health Care Financing Administration, the hospital shall file a copy of the report with the Division of Research and Statistical Services of the State Budget and Control Board including the following information:

(1) information detailing its assets and liabilities; and

(2) a statement of income, expenses, profits, and losses.

(B) The division shall promulgate regulations to carry out this section.

**SECTION 44‑6‑180.** Confidentiality of patient records; controlled dissemination of data; violations and penalties.

(A) Patient records received by counties, the department, or other entities involved in the administration of the program created pursuant to Section 44‑6‑150 are confidential. Patient records gathered pursuant to Section 44‑6‑170 are also confidential. The division shall use patient‑identifiable data collected pursuant to Section 44‑6‑170 for the purpose of linking various data bases to carry out the purposes of Section 44‑6‑170. Linked data files must be made available to those agencies providing data files for linkage. No agency receiving patient‑identifiable data collected pursuant to Section 44‑6‑170 may release this data in a manner such that an individual patient or provider may be identified except as provided in Section 44‑6‑170. Nothing in this section may be construed to limit access by a submitting provider or its designee to that provider’s information.

(B) A person violating this section is guilty of a misdemeanor and, upon conviction, must be fined not more than five thousand dollars or imprisoned not more than one year, or both.

**SECTION 44‑6‑190.** Applicability of Administrative Procedures Act; compliance with Medicaid disclosure rules.

The department may promulgate regulations pursuant to the Administrative Procedures Act. Appeals from decisions by the department are heard pursuant to the Administrative Procedures Act, Administrative Law Judge, Article 5, Chapter 23 of Title 1 of the 1976 Code.

The department shall promulgate regulations to comply with federal requirements to limit the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of the Medicaid program.

**SECTION 44‑6‑200.** Falsification of information; penalties.

(A) A person who commits a material falsification of information required to determine eligibility for the Medically Indigent Assistance Program is guilty of a misdemeanor and, upon conviction, must be fined not more than five hundred dollars or imprisoned for not more than one year, or both.

(B) Unless otherwise specified in this chapter, an individual or facility violating this chapter or a regulation under this chapter is guilty of a misdemeanor and, upon conviction, must be fined not more than one hundred dollars for the first offense and not more than five thousand dollars for a subsequent offense.

**SECTION 44‑6‑220.** Notice requirements on nursing home admission applications.

All applications for admission to a nursing home must contain a notice, to be signed by the applicant, stating:

“Eligibility for Medicaid‑sponsored long‑term care services is based on income and medical necessity. To qualify for assistance through the Medicaid program, a nursing home patient must need intermediate or skilled nursing care as determined through an assessment conducted by Medicaid program staff. The fact that a patient has already been admitted to a nursing home is not considered in this determination. It is possible that a patient could exhaust all other means of paying for nursing home care and meet Medicaid income criteria but still be denied assistance due to the lack of medical necessity.

“It is recommended that all persons seeking admission to a nursing home be assessed by the Medicaid program prior to admission. This assessment will provide information about the level of care needed and the viability of community services as an alternative to admission. The department may charge a fee, not to exceed the cost of the assessment, to persons not eligible for Medicaid‑sponsored long‑term care services.”

ARTICLE 3.

CHILD DEVELOPMENT SERVICES

**SECTION 44‑6‑300.** Child development services to be established.

The Department of Health and Human Services shall establish child development services in the following counties: Allendale, Bamberg, Barnwell, Calhoun, Cherokee, Chester, Chesterfield, Fairfield, Jasper, Lexington, Newberry, and Orangeburg. The services established in each county must provide at least thirty slots for the children of that county.

**SECTION 44‑6‑310.** Expansion of existing child development services.

The Department of Health and Human Services shall expand existing child development services in the following counties: Beaufort, Charleston, Florence, Greenville, Hampton, and Richland. The services in each county must be expanded to provide at least twenty new slots but no more than sixty new slots for the children of each county.

**SECTION 44‑6‑320.** Appropriations.

The establishment and expansion of the child development services mandated by Sections 44‑6‑300 and 44‑6‑310 must be accomplished within the limits of the appropriations provided by the General Assembly in the annual General Appropriations Act for this purpose and in accordance with the Department of Health and Human Services policies for child development services funded through Title XX.

ARTICLE 4.

INTERMEDIATE SANCTIONS FOR MEDICAID CERTIFIED NURSING HOME ACT

**SECTION 44‑6‑400.** Definitions.

As used in this article:

(1) “Department” means the Department of Health and Human Services.

(2) “Nursing home” means a facility subject to licensure as a nursing home by the Department of Health and Environmental Control and subject to the permit provisions of Article 2, Chapter 7 of Title 44 and which has been certified for participation in the Medicaid program or has been dually certified for participation in the Medicaid and Medicare programs.

(3) “Resident” means a person who resides or resided in a nursing home during a period of an alleged violation.

(4) “Survey agency” means the South Carolina Department of Health and Environmental Control or any other agency designated to conduct compliance surveys of nursing facilities participating in the Title XIX (Medicaid) program.

**SECTION 44‑6‑420.** Enforcement actions; considerations; proportionality to violations.

When the department is notified by the survey agency that a nursing home is in violation of one or more of the requirements for participation in the Medicaid program, it may take enforcement action as follows:

(1) if the nursing home is dually certified for participation in both the Medicare and Medicaid programs, the department shall coordinate any enforcement action with federal authorities and shall defer to the actions of these federal authorities to the extent required by federal statute or regulation;

(2) if the nursing home is only certified for participation in the Medicaid program and is not certified for participation in the Medicare program, the department may take any enforcement action authorized under federal statute or regulation that would have been available for use by federal authorities if the nursing home had been dually certified;

Any enforcement actions taken solely by the department under item (2) must be proportionate to the scope and severity of the violations and also shall take into account the factors considered by federal authorities in similar enforcement actions. Dually certified nursing homes and nursing homes only certified for participation in the Medicaid program must be subjected to comparable enforcement actions for comparable violations.

**SECTION 44‑6‑470.** Fines; use of funds collected.

Any use of funds collected by the department as a result of the imposition of civil monetary penalties or other enforcement actions must be for a purpose related to the protection of the health and property of residents of nursing homes that participate in the Medicaid program. These funds may be used for the cost of relocating residents to other nursing homes, if necessary, and also may be used to reimburse residents for personal funds lost as a result of violations of the requirements for participation in the Medicaid program by the nursing home. In addition, these funds may be used for other costs directly associated with enforcement or corrective measures at facilities found to be out of compliance with the requirements for participation in the Medicaid program or for any other purpose that enhances or improves the health and quality of life for residents. These requirements for the use of funds collected also apply to funds received by the department that are collected as the result of enforcement actions directed by federal authorities.

**SECTION 44‑6‑530.** Federal jurisdiction.

Before instituting an action under this article, the Department of Health and Human Services shall determine if the Secretary of the United States Department of Health and Human Services has jurisdiction under federal law. In such cases, it shall coordinate its efforts with the secretary to maintain an action against the nursing home. In an action against a nursing home owned and operated by the State of South Carolina, the secretary has exclusive jurisdiction.

**SECTION 44‑6‑540.** Authority for rulemaking, and to ensure compliance with Medicaid participation.

The department is authorized to promulgate regulations, pursuant to the Administrative Procedures Act, to administer this article, and to ensure compliance with the requirements for participation in the Medicaid program.

ARTICLE 5.

GAP ASSISTANCE PHARMACY PROGRAM FOR SENIORS ACT

**SECTION 44‑6‑610.** Citation of article.

This article may be cited as the “Gap Assistance Pharmacy Program for Seniors (GAPS) Act”.

**SECTION 44‑6‑620.** Definitions.

For purposes of this article:

(1) “Department” means the South Carolina Department of Health and Human Services.

(2) “Prescription drugs” means outpatient prescription drugs that have been approved by the United States Food and Drug Administration. “Prescription drugs” do not include experimental drugs and over‑the‑counter pharmaceutical products.

(3) “Program” means the Gap Assistance Pharmacy Program for Seniors (GAPS) created pursuant to this article.

(4) “Medicare Part D Prescription Drug Plan” means a Prescription Drug Plan that has been approved by the Centers for Medicare and Medicaid Services (CMS) to provide Medicare Part D prescription drugs to Medicare beneficiaries in South Carolina.

(5) “GAPS Participating Medicare Part D Prescription Drug Plan” means Prescription Drug Plans that have executed a contract with the department to provide prescription drug coverage to eligible individuals during the annual Medicare Part D coverage gap.

**SECTION 44‑6‑630.** Creation of GAPS program; purpose.

(A) There is created within the Department of Health and Human Services the Gap Assistance Pharmacy Program for Seniors (GAPS) program. The purpose of this program is to coordinate, beginning January 1, 2006, with Medicare Part D Prescription Drug Plans to provide to low‑income seniors in this State assistance with costs for prescription drugs during the annual Medicare Part D coverage gap.

(B) The program must provide assistance with prescription drugs that:

(1) have been approved by the United States Food and Drug Administration; and

(2) are included in the enrollee’s selected GAPS participating Medicare Part D Plan formulary.

**SECTION 44‑6‑640.** Administration of program; assistance of other agencies or organizations; enrollment fee.

(A) This program must be administered by the Department of Health and Human Services. The department may designate, or enter into contracts with, other entities including, but not limited to, other states, other governmental purchasing pools, and nonprofit organizations to assist in the administration of this program.

(B) The department may establish an enrollment fee that must be used to fund the administration of this program.

(C) When requested by the department, other state agencies shall provide assistance or information necessary for the administration of this program.

**SECTION 44‑6‑650.** Eligibility; benefits.

(A) To be eligible to enroll in this program a person must:

(1) have attained the age of sixty‑five years;

(2) be a resident of this State;

(3) be enrolled in a GAPS participating Medicare Part D Drug Plan;

(4) satisfy annual income, resources, and other criteria established by the department;

(5) pay the enrollment fee, if any, as established by the department.

(B) An enrollee is entitled to benefits under this program during the coverage gap when the enrollee’s annual prescription drug costs have reached the point that standard Medicare Part D benefits are no longer available. The GAPS benefits terminate when the enrollee’s annual out‑of‑pocket prescription drug expenses have reached the point that catastrophic Medicare Part D benefits become available.

**SECTION 44‑6‑660.** Evaluation of cost effectiveness; annual report.

(A) The department shall maintain data to allow evaluation of the cost effectiveness of the program.

(B) Beginning with fiscal year 2006‑2007, the department shall include in its annual report, a report on the GAPS program.

**SECTIONS 44‑6‑670, 44‑6‑680.** Omitted by 2006 Act No. 233, Section 1, eff February 21, 2006.

**SECTIONS 44‑6‑670, 44‑6‑680.** Omitted by 2006 Act No. 233, Section 1, eff February 21, 2006.

ARTICLE 6.

TRUSTS AND MEDICAID ELIGIBILITY

**SECTION 44‑6‑710.** Treating application of person deemed ineligible because of Medicaid qualifying trust as undue hardship case.

If an applicant for Medicaid for nursing home care would be ineligible because a trust established for the applicant was deemed a Medicaid qualifying trust or resources in the trust were deemed an improper transfer of resources, the person’s application must be treated as a case of undue hardship under federal law if all of the criteria in Section 44‑6‑720 are met. For the purposes of this section, ‘Medicaid qualifying trust’ has the same meaning as set forth in 42 U.S.C. Section 1396a(k).

**SECTION 44‑6‑720.** Requirements for qualifying for undue hardship waiver.

(A) To be considered for a waiver due to undue hardship, the applicant must meet all other applicable eligibility criteria for assistance. If the federal “transfer of resources” rule set forth in 42 U.S.C. Section 1396p(c), as amended, applies to the applicant, then no undue hardship waiver may be granted until the period of ineligibility has expired. For the purposes of this subsection, the maximum length of ineligibility is extended to sixty months from the date of any improper transfer.

(B) The trust established for the applicant must meet the following criteria:

(1) the applicant’s monthly gross income from all sources, without reference to the trust, exceeds the income eligibility standard for Medicaid then in effect but is less than the average private pay rate for nursing home care for the State;

(2) the property used to fund the trust is limited to monthly unearned income owned by the applicant, including any pension payment;

(3) the applicant and the state Medicaid program are the sole beneficiaries of the trust;

(4) the entire income and corpus of the trust, or as much as may be distributed each month without violating federal requirements for federal financial participation, must be distributed each month for expenses related to the applicant’s nursing home care that are approved under the Medicaid program, except that:

(a) an amount reasonably necessary to maintain the existence of the trust, as approved by the Medicaid program, may be retained in the trust; and

(b) deductions may be distributed from the trust to the same extent deductions from the income of a nursing home resident who is not a trust beneficiary are allowed under the Medicaid program, which shall include:

(i) monthly personal needs allowance;

(ii) payments to the beneficiary’s community spouse or dependent family members as provided and in accordance with state and federal law;

(iii) specified health insurance costs and special medical services provided under Title XIX of the federal “Social Security Act”, 42 U.S.C. Section 1396a(r), as amended; and

(iv) other deductions provided in regulations of the State Health and Human Services Finance Commission;

(5) upon the death of the beneficiary, a remainder interest in the corpus of the trust passes to the State Health and Human Services Finance Commission. The commission shall remit the state share of the trust to the general fund; and

(6) the trust is not subject to modification by the beneficiary or the trustee without the approval of the state Medicaid program.

**SECTION 44‑6‑725.** Promissory notes received by Medicaid applicant or recipient.

Any promissory note received by a Medicaid applicant or recipient or the spouse of a Medicaid applicant or recipient in exchange for assets which if retained by the applicant or recipient or his spouse would cause the applicant or recipient to be ineligible for Medicaid benefits, shall, for Medicaid eligibility purposes, be deemed to be fully negotiable under the laws of this State unless it contains language plainly stating that it is not transferable under any circumstances. A promissory note will be considered valid for Medicaid purposes only if it is actuarially sound, requires monthly installments that fully amortize it over the life of the loan, and is free of any conditional or self‑canceling clauses.

**SECTION 44‑6‑730.** Promulgation of regulations to implement article and comply with federal law; amendment of state Medicaid plan consistent with article.

The State Health and Human Services Finance Commission shall promulgate regulations as are necessary for the implementation of this article and as are necessary to comply with federal law. In addition, the commission shall amend the state Medicaid plan in a manner that is consistent with this article.

ARTICLE 7.

RECOGNITION AND DESIGNATION OF FEDERALLY QUALIFIED HEALTH CENTERS, RURAL HEALTH CLINICS, AND RURAL HOSPITALS

**SECTION 44‑6‑910.** Health facilities recognized and designated as providers for underserved patients; when hospital in urban area considered “rural.”

(A) Federally Qualified Health Centers (FQHC’s), Rural Health Clinics (RHC’s), and Rural Hospitals are recognized and designated as essential community providers for underserved patients which include Medicaid and Medicare recipients, the underinsured, and the uninsured. These populations require more extensive services by community‑based providers, and the FQHC’s, RHC’s, and Rural Hospitals have extensive experience and knowledge in providing quality, cost‑effective care for these populations. The State shall include these essential community providers as contracted entities in any formulation of the state health care system. The inclusion of FQHC’s, RHC’s, and Rural Hospitals as contracted entities in the state health care system recognizes the importance of these providers to South Carolina and assures that the reimbursement to these essential community providers will be funded through cost‑based reimbursement or a capitated fee based on reasonable costs.

(B) A hospital located in an urban area (MSA County), can be considered “rural” for the purposes of the Medicare Rural Hospital Flexibility Program if it meets the following criteria:

(1) enrolled as both a Medicaid and Medicare provider and accepts assignment for all Medicaid and Medicare patients;

(2) provides emergency health care services to indigent patients;

(3) maintains a twenty‑four hour emergency room;

(4) staffs fifty or less acute care beds; and

(5) located in a county with twenty‑five percent or more rural residents, as defined by the most recent United States decennial census.

ARTICLE 8.

MEDICAID PHARMACY AND THERAPEUTICS COMMITTEE

**SECTION 44‑6‑1010.** Pharmacy and Therapeutics Committee established; membership.

There is created within the Department of Health and Human Services the Pharmacy and Therapeutics Committee. The committee must consist of fifteen members appointed by the director and serving at the pleasure of the director of the department. The members must include eleven physicians and four pharmacists licensed to practice in South Carolina and actively engaged in providing services to the South Carolina Medicaid population. The physicians may include, but are not limited to, doctors who have experience in treating diabetes, cancer, HIV/AIDS, mental illness, and hemophilia and who practice in internal medicine, primary care, and pediatrics.

**SECTION 44‑6‑1020.** Adoption of bylaws; election of chairman and vice chairman; compensation; meetings; public comment on clinical and patient care data from Medicaid providers.

The committee shall adopt bylaws that include, at a minimum, the length of membership. A chairman and a vice chairman shall be elected on an annual basis from the committee membership. Committee members must not be compensated for service to the committee. However, committee members may be reimbursed for actual and necessary expenses incurred by discharging committee duties in an amount not to exceed the mileage and subsistence amounts allowed by law for members of boards, commissions, and committees. The committee must meet at least quarterly and may meet at other times in the chairman’s or the director’s discretion. Committee meetings are subject to the provisions of the Freedom of Information Act. The department shall publish notice of regular business meetings of the committee at least thirty days before the meeting. However, the director or chairman may call special meetings of the committee and provide notice as soon as practical. The committee must provide for public comment, including comment on clinical and patient care data from Medicaid providers, representatives of the pharmaceutical industry, and patient advocacy groups. Proprietary information as defined in the trade secret law shall not be discussed. Trade secrets as defined in Section 30‑4‑40(a)(1) and relevant federal law must not be publicly disclosed.

**SECTION 44‑6‑1030.** Recommendation of therapeutic classes of drugs to be included on preferred drug list.

The committee must recommend to the department therapeutic classes of drugs that should be included on a preferred drug list. For those recommended classes, the committee shall recommend the drug or drugs considered preferred within that class based on safety and efficacy. In determining safety and efficacy, the committee may consider all submitted public comment or clinical information including, but not limited to, scientific evidence, standards of practice, peer‑reviewed medical literature, randomized clinical trials, pharmacoeconomic studies, and outcomes research data. The committee also shall recommend prior authorization criteria for nonpreferred drugs in the recommended therapeutic classes.

**SECTION 44‑6‑1040.** Preferred drug list program; procedures to be included.

Any preferred drug list program implemented by the department must include:

(1) procedures to ensure that a request for prior authorization that has no material defect or impropriety can be processed within twenty‑four hours of receipt;

(2) procedures to allow the prescribing physician to request and receive notice of any delays or negative decision in regard to a prior authorization;

(3) procedures to allow the prescribing physician to request and receive a second review of any denial of a prior authorization request; and

(4) procedures to allow a pharmacist to dispense an emergency, seventy‑two hour supply of a drug requiring prior authorization without prior authorization if the pharmacist:

(a) has made a reasonable attempt to contact the physician and request that the prescribing physician secure prior authorization; and

(b) reasonably believes that refusing to dispense a seventy‑two‑hour supply would unduly burden the Medicaid recipient and produce undesirable health consequences.

**SECTION 44‑6‑1050.** Prior authorization for drug; refills; appeals.

A grant of prior authorization for a drug is specific to the drug, rather than the actual prescription, and extends to all refills allowed pursuant to the original prescription and to subsequent prescriptions for the same drug at the same dosage provided the time allowed by the prior authorization has not expired. A Medicaid recipient who has been denied prior authorization for a prescribed drug is entitled to appeal this decision through the department’s appeals process.