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Gateway Policy Explorer: Long-Term Care Series

South Carolina, USA

Long-Term Care In-Kind Benefit Plan Details

1992-2025

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Preface

This document is intended for researchers who want to understand the evolution of policy or the policy in place at a particular point in time. This document is not intended for financial advice or to aid in decision-making. The authors have made significant effort to identify and collect historical information pertaining to these policies, to accurately represent these policies, and to communicate how policies may interact to determine legal requirements, eligibility for benefits, and/or benefits levels. The policies presented in this document focus on rules applicable to most individuals aged 50 and older from 1992. Many systems include special policies or alternative eligibility rules for specific groups. We encourage all users to complete their own review of literature in this area depending on the research questions they have in mind.

If you have feedback or questions or identify an error, please contact policy@g2aging.org.

Background — *Gateway Policy Explorer: Long-Term Care Series*

The *Gateway Policy Explorer* (http://g2aging.org/policy-explorer) is part of the Gateway to Global Aging Data (http://g2aging.org) project. The *Long-Term Care Series* captures historical policy that affects the birth cohorts of respondents in the surveys covered by the Gateway. It was motivated by the rapid evolution of policies affecting older people across the world. As the Health and Retirement Study (HRS) began in 1992 and many of the international network of studies (HRS-INS) cover more than a decade, understanding the policies in place at the time of the survey has become more demanding for researchers.

Why are we tracking past policy? Individuals make choices based on current policies and the outcomes we see today may reflect responses to past policies. When interpreting the survey responses of individuals, an understanding of the policy environment under which those individuals operate is critical. The collection of contextual information in the *Gateway Policy Explorer* aims to support researchers who want to understand or use policy changes in their research and provide context for longitudinal or cross-country differences. Over the period 2023–2026 the *Gateway Policy Explorer* will be expanded to include information on retirement, long-term care, education, and other policies affecting the life cycle.

The key dimensions to the *Gateway Policy Explorer: Long-Term Care Series* are country and time. In the United States, policy is reported at the state level. We prioritize data collection for each country or state based on its first interview wave and are continuing to expand our data collection back in time to 1992, the earliest survey date in the HRS-INS.

A separate document, like this one, is developed for each country or state and each broad category of policies covered in the *Gateway Policy Explorer: Long-Term Care Series*.

South Carolina, USA

In-Kind Benefits

Plan details 1992-2025 * †

Public long-term care (LTC) benefits in South Carolina are primarily provided by Medicaid, a public health insurance program for low-income individuals. Enrollment in Medicaid is voluntary.

In South Carolina, LTC services are primarily provided as in-kind benefits. LTC benefits vary by program, with separate programs for home-based care, community care, residential care, and some that cover a variety of care. Programs vary in eligibility criteria.

Since 1992, South Carolina's Medicaid LTC system has been subject to 1 major policy reform: the implementation of a new home and community-based services program in 2006.

Key Dates

First law: 1965

Major changes since 1992: 2006

Contents

* If you have questions or suggestions, please contact policy@g2aging.org.

† Detailed information and definitions are provided in tables, formulas and a glossary at the end of this document. To facilitate switching back and forth, this document is designed with hyperlinks. Most PDF readers have shortcuts that permit a reader to return to the previous location after selecting a hyperlink. In Adobe Acrobat on a PC: "Alt" + "←"; In Adobe Acrobat on a MAC: "command" + "←"; In Preview on a MAC: "command" + "[".

Chapter 1: Policy enacted 1992-2005

Overview

Long-term care (LTC) benefits in South Carolina are primarily provided by Medicaid, a public health insurance program for low-income individuals. Medicaid in South Carolina is administered at the state level by the South Carolina Department of Health and Human Services (SCDHHS), and enrollment is voluntary.

Eligibility for Medicaid is determined by eligibility tracks that may have different requirements, such as income and asset limits. LTC benefits in South Carolina are mostly provided through state plan benefit programs (Home Health Services, Nursing Facility Care), or through federally approved home-and community-based services (HCBS) LTC programs (Elderly and Disabled program).

Beneficiaries receiving state plan benefits must establish medical necessity for each service prescribed by a physician. Home Health services provide home care for beneficiaries who have established medical necessity, while Nursing Facility Care only provides care in a nursing home. State plan benefits are not mutually exclusive, and a beneficiary may receive multiple benefits if eligible. Once a specific state plan benefit is determined to be medically necessary, the beneficiary may immediately receive care. People covered by the Elderly and Disabled program are able to receive a variety of LTC benefits if deemed medically eligible, such as adult day health care and home delivered meals. Those applying for the Elderly and Disabled program are not immediately guaranteed care, as the program has strict enrollment limits. If the program is at capacity, individuals are placed on a waiting list until a program slot becomes available.

Benefit programs vary in dependence requirements. Home Health requires the individual to have a medical necessity for services, while Nursing Facility and Elderly and Disabled program beneficiaries must meet a nursing facility level of care (NFLOC) based on a comprehensive assessment before admission.

Policy changes during this period:

- (1993) On October 26, the SCDHHS Finance Commission approved the addition of environmental and home modifications as a service provided under the Elderly and Disabled program (SCDHHS, 1994).
- (1993) Effective July 1 individuals can meet Medicaid financial eligibility requirements by setting up a qualified income trust (QIT) to "spend down" excess income with approved medical expenses (SCDHHS, 1994).
- (1994) Effective July 1 South Carolina implemented an estate recovery program to recover Medicaid payments for nursing facility services, HCBS, and related hospital and prescription drug services paid on behalf of a Medicaid enrollee (SCDHHS, 1994; SCGA, 2024a § 43-7-460).
- (1996) The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) restricted most legal immigrants entering the United States after August 22, 1996 from receiving federally funded Medicaid (and some other public assistance) for at least five years after immigration (US Congress, 1996).
- (2003) South Carolina implemented a new SC Choice program to pilot the provision of consumer-directed HCBS to a limited number of program beneficiaries. The program was initially implemented in Spartanburg, Cherokee, and Union Counties (KFF, 2003; CMS, 2008).

Statutory basis

Federal Law for Medicaid: 42 U.S.C. 1396-1 to 1396w-5, Title XIX of the Social Security Act (SSA, 2025b)

South Carolina Law for Medicaid

- South Carolina Code of Laws, Title 43: Social Services, Chapter 7 - Medical and Hospital Care (SCGA, 2024a)
- South Carolina Code of Laws, Title 44: Health, Chapter 6 - Department of Health and Human Services (SCGA, 2024b)
- South Carolina Code of Regulations, Chapter 126: Department of Health and Human Services (SCGA, 2024c)

Financing

Source of financing

Funding for Medicaid is split between federal and state financing. The federal government matches state spending for individuals eligible for services, and the matching rate is determined by a formula based on a state's per capita income relative to other states, called the Federal Medical Assistance Percentage (FMAP). The federal share for South Carolina Medicaid spending on beneficiaries in fiscal year 1992 was 72.66%. See Table 1 for historical FMAPs. The standard FMAP applies to most Medicaid spending. The match rate for most administrative functions is 50%, although some functions are matched at a higher rate.

Coverage

This section discusses the scope of risks covered and the requirements to be eligible for benefits when the need for care arises. Dependence requirements are discussed in the later section on *Benefit Eligibility*.

Risk covered definition

Medicaid LTC serves individuals with limited income and assets who need assistance with physical, functional, and cognitive impairments and/or other limitations of daily living that may prevent them from being fully independent. For example, many individuals pursue LTC for assistance with activities of daily living (ADLs), which are fundamental tasks like eating, dressing, and showering. If the beneficiary meets level of care requirements, Medicaid will also pay for 24-hour care in a nursing facility.

Eligible population

There exist several LTC benefits and programs under Medicaid, many of which have age or dependence-related eligibility requirements that must be met before service authorization or program enrollment. However, all programs first require eligibility for Medicaid. Here we detail eligibility for South Carolina Medicaid, followed by additional requirements for specific programs under Medicaid.

Medicaid

States are federally required to provide Medicaid coverage to certain categorical populations, called the mandatory categorically needy. While there are many groups within this track (e.g., pregnant women, children), we only detail eligibility information for categories that are most likely to require LTC (e.g., aged or disabled individuals). Additionally, states may opt in to cover additional categorical populations, called the optional categorically needy. There is substantial variation in who is covered as optional categorically needy across states. Here we detail the eligibility criteria for the most relevant eligibility tracks and coverage groups in South Carolina.

Eligibility for Medicaid in South Carolina for people needing LTC services is primarily attained by satisfying at least 1 of 3 alternative eligibility tracks:

Eligibility Track 1: Mandatory Categorically Needy

- 1a. Supplemental Security Income (SSI) recipients
  - Income requirements: Monthly income may not exceed the maximum SSI benefit amount (SCDHHS, 1992).[1] In 1992, the monthly federal benefit amount was $422 for an individual and $633 for a couple. See Table 2 for historical monthly benefit amounts.
  - Asset requirements: Resources may not exceed $2,000 for an individual and $3,000 for a couple (SCDHHS, 1992). This standard has remained the same since 1989.
    - Asset transfer: With some exceptions, applicants who dispose of resources or income for less than fair market value on or after the look back date will be subject to a period of ineligibility for LTC services.[2]
  - Citizenship/immigration requirements: The applicant must be a South Carolina resident and a U.S. citizen or non-citizen who meets additional eligibility requirements.[3] After 1996, the applicant must be a U.S. citizen or qualified non-citizen, such as a lawfully admitted permanent resident, refugee admitted under Section 207 of the Immigration and Nationality Act (INA), or someone granted asylum under Section 208 of the INA—individuals who entered the United States on or after August 22, 1996, are ineligible for SSI and Medicaid for the first 5 years as a lawfully admitted permanent resident. See SSA (2024) for additional information.
  - Other requirements
    - The applicant must be at least age 65, blind, or disabled.[4]

Eligibility Track 2: Optional Categorically Needy

- 2a. Institutional rules for people receiving LTC
  - Income requirements: Monthly income may not exceed 300% of the monthly federal SSI amount (SCDHHS, 1992). In 1992 this was $1,266 for an individual. Income for this track is evaluated independently from the applicant's spouse or other dependents. See Table 2 for historical income limits. Additional income disregards exist if a person is institutionalized or enrolled in the Elderly and Disabled program and has a spouse residing in the community.[5] See Table 3 for historical monthly spousal disregards. Effective July 1, 1993, if an individual has monthly income above this threshold they can set up a Qualified Income Trust to meet this standard (SCDHHS, 1994).
  - Asset requirements: Resources may not exceed $2,000 for an individual (SCDHHS, 1992). Income for this track is evaluated independently from the applicant's spouse or other dependents. Additional asset disregards exist if a person is institutionalized or enrolled in the Elderly and Disabled program and has a spouse residing in the community.[6] See Table 3 for historical monthly spousal disregards.

        - Asset transfer: Same as eligibility track 1a.
    - ◇ Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
    - ◇ Other requirements
        - The applicant must be receiving Medicaid Nursing Facility Care or be enrolled in a home or community-based LTC program (e.g., Elderly and Disabled program).
- 2b. Federal Poverty Level (FPL) aged and disabled
    - ◇ Income requirements: Monthly income may not exceed 100% of the FPL (SCDHHS, 1992). In 1992, this was $568 for an individual and $766 for a couple. See Table 2 for historical income limits. Additional income disregards exist if a person is institutionalized or enrolled in the Elderly and Disabled program and has a spouse residing in the community.[5] See Table 3 for historical monthly spousal disregards.
    - ◇ Asset requirements: Resources may not exceed $4,000 for an individual and $6,000 for a couple (SCDHHS, 1992). Additional asset disregards exist if a person is institutionalized or enrolled in the Elderly and Disabled program and has a spouse residing in the community.[6] See Table 3 for historical monthly spousal disregards.
        - Asset transfer: Same as eligibility track 1a.
    - ◇ Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
    - ◇ Other requirements
        - The applicant must be at least age 65 or disabled.[4]

Other Eligibility Tracks

There exist alternative eligibility tracks targeted at other populations. Some of these tracks include:

- Breast and Cervical Cancer Program: Provides Medicaid coverage including LTC for certain women with breast or cervical cancer—from 2002 (CMS, 2001)

Once eligibility for Medicaid has been determined, beneficiaries may have to meet additional eligibility criteria in order to become eligible for specific LTC health benefit programs under Medicaid. Additional program criteria (if applicable) are detailed below.

Home Health Services, Nursing Facility Care

There are no additional conditions for coverage. Benefit qualification depends on minimum level of dependence (this is detailed in the *Benefit Eligibility* section of this policy period).

Elderly and Disabled

Beyond meeting minimum level of dependence requirements, applicants must be at least age 65 or age 18-64 and disabled. If the program reaches enrollment capacity, the applicant is placed on a waiting list until a spot becomes available.

Other community-based programs

There exist several home and community-based services (HCBS) programs targeted at older adults that are omitted due to limited enrollment. Some of these programs include:

- HIV/AIDS Program: Provides HCBS to individuals diagnosed with AIDS or HIV infection
- Palmetto SeniorCare: South Carolina's Program of All-Inclusive Care for the Elderly (PACE) providing medical and social services to elderly and disabled individuals in a limited number of counties throughout the state
- Mechanical Ventilator Dependent Program—from 1994: Provides HCBS to elderly and disabled individuals who require mechanical ventilation
- Home Again—from 2002: Nursing home transition program under the federal Money Follows the Person initiative
- Integrated Personal Care program—from 2002: Provides personal care services (PCS) to individuals residing in community residential care facilities
- South Carolina Choice program—from 2003: Provides consumer-directed HCBS to individuals in a limited number of counties throughout the state

Benefit

Home care benefit

Home care benefits vary by health benefit program. The details of the 3 largest programs are summarized below.

Home Health Services

Home health provides:

- Skilled nursing services: Intermittent or part-time nursing services, such as colostomy and ileostomy care, tracheotomy aspiration, levin tube care, provided by a registered nurse or licensed practical nurse
- Home health aide services: Semi-skilled care, such as simple wound care, vital monitoring, and personal care

Home health service visits are limited to 75 visits per year (CMS, 2006).

Nursing Facility Care

Nursing facility care does not provide home care.

Elderly and Disabled

The Elderly and Disabled program provides personal care services (PCS), referred to to as Personal Care Aide services during this policy period, which provides (SCDHHS, 1992; SCDHHS 1994):

- Assistance with activities of daily living (ADLs), such as eating, toileting, bathing, grooming, dressing, ambulation, and transferring
- Assistance with instrumental activities of daily living (IADLs), such as personal laundry, light housekeeping, shopping, meal preparation, and medication administration

Community care

Community care benefits vary by health benefit program. The details of the 3 largest programs are summarized below.

Home Health Services, Nursing Facility Care

These programs do not provide community care.

Elderly and Disabled

The Elderly and Disabled program provides adult day health care (ADHC). ADHC centers provide daytime supervision, personal care assistance, and sometimes meals to recipients in a group setting (SCDHHS 1994).

Residential care

Residential care benefits vary by health benefit program. The details of the 3 largest programs are summarized below.

Home Health Services, Elderly and Disabled

These programs do not provide residential care.

Nursing Facility Care

South Carolina Medicaid covers residential care in a nursing facility. Care is provided 24 hours a day in a nursing facility and includes all services necessary to meet patient needs. Services may include the following (SCDHHS, 1992; SCDHHS, 2018; SCDHHS, 2023b):

- Physician services
- Room and board
- All general nursing services, including restorative nursing
- Personal hygiene care
- Medical supplies and equipment
- Rehabilitative services, including physical, speech, and occupational therapies

Other benefits

Other care benefits vary by health benefit program. Below we detail other benefits provided by Medicaid state plan benefit programs (Home Health Services, Nursing Facility Care), followed by South Carolina's largest home and community-based services (HCBS) program.

South Carolina Medicaid provides additional state plan benefits related to LTC:

- Durable medical equipment and supplies: Items that assist with an illness or injury, and may include walkers, wheelchairs, suction pumps, bandages, or similar aids —this is a required benefit under Home Health Services
- Non-emergency medical transportation: Medically necessary transportation for any recipient and personal care attendant or escort, if required, who have no other means of transportation available to any Medicaid-compensable service for the purpose of receiving treatment, medical evaluation, or therapy

Elderly and Disabled

The Elderly and Disabled program provides the following services in addition to those offered under the state plan, unless otherwise noted (SCDHHS, 1992; SCDHHS 1994):

- Case management: Services that assist the participant in developing, authorizing, and monitoring the plan of care
- Home-delivered meals: Provision of at least one nutritionally sound meal per day to persons who are dependent, aged, or physically disabled and unable to care for their nutritional needs
- Respite: Services provided to participants unable to care for themselves that are furnished on a short-term basis because of the absence of or need for relief for those persons normally providing care for the participant
- Medical social services: Services provided by medical social workers intended to ease environmental, social, or situational barriers to accessing or benefiting from community-based services
- Environmental modification—from 1993: Physical adaptations to the home, which are necessary to assure the health, welfare, and safety of the participant

Provision of care

Medicaid benefits may be provided by non-profit organizations, home health agencies, hospitals, nursing facilities, and for-profit providers, all of which are licensed and overseen by the South Carolina Department of Health and Human Services (SCDHHS). Providers that accept Medicaid payment rates and meet licensing requirements may participate in Medicaid.

Home Health Services

Skilled nursing services are provided by registered nurses, and home health aide services are provided by home health aides employed by state-certified home health agencies. Home health aide services are provided under the direction of a registered nurse (SCDHHS, 1992).

Nursing Facility Care

Nursing facility services are provided and supervised by registered nurses and other nursing personnel of state-certified nursing facilities (SCGA, 2024b § 126-425; 42 CFR 483.30).

Elderly and Disabled

Elderly and Disabled Adult program services are provided by authorized staff of state-approved provider agencies (SCGA, 2024 § 126-425).

Benefit eligibility

Qualifying period

Potential users may apply at any time.

Minimum level of dependence

The minimum level of dependence varies by health benefit program. The details of the 3 largest programs are summarized below. Information on how level of care is assessed is detailed in the *Care Needs Assessment* section of this policy period.

Home Health Services

As required by federal law, home health services must be medically necessary and ordered by a physician. Medically necessary services are defined as those that are necessary and reasonable for the treatment of illness or injury. The beneficiary must also be homebound, defined as being confined to their place of residence due to a medical or health condition (42 CFR 440.70; SCDHHS, 2019b).

Nursing Facility Care, Elderly and Disabled

Beneficiaries must meet a nursing facility level of care (NFLOC) at either an intermediate or skilled level of care. See the *Definition of dependence* section for full eligibility criteria that define each of these dependence levels (SCDHHS, 1995).

Duration of benefit

Reassessments of eligibility vary by health benefit program. Below we detail reassessments for Medicaid, followed by reassessments for the 3 largest programs.

Medicaid

Federal law requires states to renew Medicaid eligibility at least every 12 months (42 CFR 435.916).

Home Health Services

Federally mandated Medicaid recertification for home health occurs every 60 days through a physician's review of the individual's plan of care, or more often if there is a change in condition, to ensure that the services continue to be medically necessary (SCDHHS, 2019b; 42 CFR 440.70).

Nursing Facility Care, Elderly and Disabled
NFLOC must be recertified every 12 months, or with a change in condition that merits a reevaluation of the beneficiary's medical condition or functional capabilities (SCDHHS, 2019a).

For recipients of nursing facility care, after admission to a nursing facility Pre-Admission Screening and Resident Review (PASRR) Level 1 Evaluations must be recertified when there is a significant change in condition, and federally required quarterly and annual Minimum Data Set (MDS) assessments must demonstrate that the resident continues to meet the criteria for skilled nursing facility care (42 CFR 483.20; 42 CFR 483.128).

Means testing

In-kind benefits are means-tested. Depending on the eligibility track used to qualify for Medicaid, the income and asset limits may differ. Means testing does not differ by health benefit program beyond the requirements used to qualify for Medicaid.

Age requirement

Age requirements vary by health benefit program. Below we detail age requirements for Medicaid, followed by age requirements for the 3 largest programs.

Medicaid
There is no age requirement for Medicaid. Age would only impact the eligibility track used to qualify for Medicaid.

Home Health Services, Nursing Facility Care
There is no age requirement.

Elderly and Disabled
The individual must be at least age 65, or 18-64 and disabled.

Care needs assessment

Definition of dependence

Definitions of dependence vary by health benefit program. The details of the 3 largest programs are summarized below.

Home Health Services
As required by federal law, home health services must be medically necessary and ordered by a physician. Medically necessary services are defined as those that are necessary for the maintenance, improvement, or protection of health or for the treatment of illness or disability. The beneficiary must also be homebound, defined as being confined to their place of residence due to a medical or health condition (SCDHHS, 2019b; 42 CFR 484.55).

Nursing Facility Care, Elderly and Disabled
Applicants must meet a nursing facility level of care (NFLOC). South Carolina separates NFLOC into intermediate and skilled levels of care, and individuals are eligible if they satisfy either of these levels (SCGA, 2024b §§ 126-304, 314).

To meet a skilled level of care, an individual must require at least 1 out of 11 approved skilled services listed in Box 3 and have at least 1 out of 4 functional deficits listed in Box 4. To meet an intermediate level of care, an individual must require at least 1 out of 4 approved intermediate services listed in Box 5 and 1 out of 4 functional deficits listed in Box 4, or at least 2 of the functional deficits listed in Box 4. In order to satisfy the criteria for a functional deficit, the individual must require extensive assistance with activities of daily living (ADLs) defined using the 5-point scale described in Box 6 (SCDHHS, 1995).

Evaluation of dependence

Evaluations of dependence vary by health benefit program. The details of the 3 largest programs are summarized below.

Home Health Services

A licensed physician or authorized practitioner such as a nurse or a physician assistant must order home health services in accordance with a plan of care that establishes medical need. Services must be authorized in advance, and the beneficiary must be seen by a physician at least every 60 days to recertify their continuing need for home health services (SCDHHS, 2019b).

Nursing Facility Care, Elderly and Disabled

Potential beneficiaries for both nursing facility care and the Elderly and Disabled program are assessed using Long Term Care Assessment Form 1718 (DHHS Form 1718). DHHS Form 1718 collects information on medical, functional, and psychobehavioral impairments, as well as environmental and demographic details in order to comprehensively assess the individuals level of care needs. The form is used to both determine whether the potential beneficiary meets the nursing facility level of care (NFLOC) requirements and to build the plan of care. For potential nursing facility residents, Form 1718 also serves as the Preadmission Screening and Resident Review (PASRR) required by the federal government to screen individuals for intellectual impairments or disabilities that may warrant specialized care in a dedicated facility, and the Minimum Data Set (MDS) is used to conduct federally mandated quarterly reviews. See Box 1 for more information on the PASRR, and Box 2 for the MDS.

The completed Form 1718 is submitted to regional offices of the SCDHHS for review along with Level of Care Certification Letter (DHHS Form 185), which certifies that the individual meets NFLOC. These certification forms must be processed prior to a beneficiary's Medicaid-covered residence in a nursing facility, or prior to the receipt of services under the Elderly and Disabled program (SCDHHS, 1995).

Evaluators

Evaluators vary by health benefit program. The details of the 3 largest programs are summarized below.

Home Health Services

A licensed physician must order home health services, develop a written plan of care, and periodically review the plan of care (SCDHHS, 2019b).

Nursing Facility Care, Elderly and Disabled

A licensed physician, nurse, or social worker must certify the beneficiary's need for nursing facility care using DHHS Form 1718 (SCDHHS, 1995).

Benefit limitations

Can you mix LTC benefits?

All South Carolina Medicaid beneficiaries receive the state plan benefit package. Some beneficiaries, if eligible, may also enroll in a federally approved HCBS program. Beneficiaries may not duplicate services across programs.

Is there free choice between cash and benefits in-kind?

The LTC system does not offer a cash benefit.

Can you receive LTC benefits with other public benefits?

It is possible to receive LTC benefits along with other benefits, such as SSI and Supplemental Nutrition Assistance Program (SNAP).

User costs

User charges

User charges vary by health benefit program. Below we detail user charges for Medicaid, followed by user charges for the 3 largest programs.

Medicaid

In 1994, South Carolina implemented an estate recovery program as required by federal law (SCGA, 2024a § 43-7-460). The acceptance of Medicaid in South Carolina creates a debt to the state agency in the total amount paid for nursing facility care for those who are permanently institutionalized or for all nursing facility care, HCBS, and related services received after the recipient reaches 55 years of age. Upon the death of the recipient, the state agency may recover the debt by filing a statement of claim against the estate of the deceased Medicaid recipient. However, the debt will not be enforced if the recipient is survived by a spouse, child, or children under 21 years of age, or a child or children who are blind or disabled (42 USC 1396p(b)(1)).

Home Health Services

Available South Carolina state documents do not detail policy on copayments or related charges for home health services during this policy period, but they are subject to federal maximum allowable cost standards that are very limited.

Nursing Facility Care

Beneficiaries are expected to contribute all of their income to the cost of care in a nursing home, except for a monthly personal needs allowance (PNA) and any funds protected by the spousal impoverishment rules. See Table 3 for historical spousal impoverishment standards. In 1992, the PNA in South Carolina is $30 (SCDHHS, 2024, p. 4).

Elderly and Disabled

There are no copayments or similar charges imposed on program participants.

Taxation of benefits

In-kind benefits are not subject to taxation.

Chapter 2: Policy enacted 2006-2025

Policy change in 2006
In 2006 South Carolina implemented a new home and community-based services (HCBS) program called Community Choices, which replaced both the Elderly and Disabled program and SC Choice, a program implemented in 2003 to pilot the provision of consumer-directed HCBS to a limited number of elderly and disabled beneficiaries. The Community Choices program offers an expanded suite of benefits including companion care services, personal emergency response systems (PERS), and telemonitoring services (SCDHHS, 2006).

Other policy changes during this period:

- (2006) The Deficit Reduction Act of 2005 enacted 2 policy changes affecting financial eligibility criteria for South Carolina Medicaid:
  - The look back period for asset transfers increases from 36 months (60 months for a trust) to 60 months for all assets.
  - A home equity limit that makes individuals with home equity above $500,000 ineligible for long-term care is implemented. Prior to 2006, in determining an applicant's assets, the value of an individual's home was usually exempt. Homes occupied by a spouse or a disabled or minor child are exempt. From 2011, this figure increases annually with inflation.
- (2007) Effective July 1, South Carolina added nursing home transition services as a Community Choices program benefit (SCDHHS, 2025).
- (2008) The asset limit used in South Carolina for eligibility track 2b (Federal Poverty Level Aged and Disabled) was increased to $6,600 for an individual and $9,910 for a couple, and began increasing each year with inflation (CMS, 2010).
- (2011) Effective February 1 the limit for Home Health Services was reduced to 50 visits per state fiscal year (SCDHHS, 2019b).
- (2011) South Carolina increased the copayment for home health services from $2 to $2.30 on April 1, and from $2.30 to $3.30 on July 11 (SCDHHS, 2010; SCDHHS, 2011)
- (2016) The nursing home transition service was removed from the Community Choices program (SCDHHS, 2016).
- (2023) Personal Care I and II were combined into one Personal Care Services benefit under the Community Choices program (SCDHHS, 2023a).
- (2024) Effective July 1 South Carolina eliminated copayments for all Medicaid recipients and services (CMS, 2024).

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Eligibility for Medicaid is determined by eligibility tracks that may have different requirements, such as income and asset limits. LTC benefits in South Carolina are mostly provided through state plan benefit programs (Home Health Services, Nursing Facility Care), or through federally approved home-and community-based services (HCBS) LTC programs (Community Choices).

Beneficiaries receiving state plan benefits must establish medical necessity for each service prescribed by a physician. Home Health services provide home care for beneficiaries who have established medical necessity, while Nursing Facility Care only provides care in a nursing home. State plan benefits are not mutually exclusive, and a beneficiary may receive multiple benefits if eligible. Once a specific state plan benefit is determined to be medically necessary, the beneficiary may immediately receive care. People covered by Community Choices are able to receive a variety of LTC benefits if deemed medically eligible, such as adult day health care and home delivered meals. Those applying for Community Choices are not immediately guaranteed care, as the program has strict enrollment limits. If the program is at capacity, individuals are placed on a waiting list until a program slot becomes available.

Benefit programs vary in dependence requirements. Home Health requires the individual to have a medical necessity for services, while Nursing Facility and Community Choices beneficiaries must meet a nursing facility level of care (NFLOC) based on a comprehensive assessment before admission.

Statutory basis

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This section discusses the scope of risks covered and the requirements to be eligible for benefits when the need for care arises. Dependence requirements are discussed in the later section on *Benefit Eligibility*.

Risk covered definition

Medicaid LTC serves individuals with limited income and assets who need assistance with physical, functional, and cognitive impairments and/or other limitations of daily living that may prevent them from being fully independent. For example, many individuals pursue LTC for assistance with activities of daily living (ADLs), which are fundamental tasks like eating, dressing, and showering. If the beneficiary meets level of care requirements, Medicaid will also pay for 24-hour care in a nursing facility.

Eligible population

There exist several LTC benefits and programs under Medicaid, many of which have age or dependence-related eligibility requirements that must be met before service authorization or program enrollment. However, all programs first require eligibility for Medicaid. Here we detail eligibility for South Carolina Medicaid, followed by additional requirements for specific programs under Medicaid.

Medicaid

States are federally required to provide Medicaid coverage to certain categorical populations, called the mandatory categorically needy. While there are many groups within this track (e.g., pregnant women, children), we only detail eligibility information for categories that are most likely to require LTC (e.g., aged or disabled individuals). Additionally, states may opt in to cover additional categorical populations, called the optional categorically needy. There is substantial variation in who is covered as optional categorically needy across states. Here we detail the eligibility criteria for the most relevant eligibility tracks and coverage groups in South Carolina.

Eligibility for Medicaid in South Carolina for people needing LTC services is primarily attained by satisfying at least 1 of 3 alternative eligibility tracks:

Eligibility Track 1: Mandatory Categorically Needy

- 1a. Supplemental Security Income (SSI) recipients
  - Income requirements: Monthly income may not exceed the maximum SSI benefit amount.[1] In 2006, the monthly federal benefit amount was $603 for an individual and $904 for a couple. See Table 2 for historical monthly benefit amounts.
  - Asset requirements: Resources may not exceed $2,000 for an individual and $3,000 for a couple. This standard has remained the same since 1989.
    - Asset transfer: With some exceptions, applicants who dispose of resources or income for less than fair market value on or after the look back date will be subject to a period of ineligibility for LTC services.[7]
    - Home equity limit: The equity interest in the individual's home may not exceed $500,000, or else they will be ineligible for LTC services. From 2011 this figure increases annually with inflation. See Table 4 for historical home equity limits.[8]
  - Citizenship/immigration requirements: The applicant must be a South Carolina resident and a U.S. citizen or a qualified non-citizen, such as a lawfully admitted permanent resident, refugee admitted under Section 207 of the Immigration

and Nationality Act (INA), or someone granted asylum under Section 208 of the INA—individuals who entered the United States on or after August 22, 1996, are ineligible for SSI and Medicaid for the first 5 years as a lawfully admitted permanent resident. See SSA (2024) for additional information.

- ◇ Other requirements
  - The applicant must be at least age 65, blind, or disabled.[4]

Eligibility Track 2: Optional Categorically Needy

- 2a. Institutional rules for people receiving LTC
  - ◇ Income requirements: Monthly income may not exceed 300% of the monthly federal SSI amount. In 2006 this was $1,809 for an individual. Income for this track is evaluated independently from the applicant's spouse or other dependents. See Table 2 for historical income limits. Additional income disregards exist if a person is institutionalized or enrolled in the Community Choices program and has a spouse residing in the community.[9] See Table 3 for historical monthly spousal disregards. If an individual has monthly income above this threshold they can set up a Qualified Income Trust to meet this standard.
  - ◇ Asset requirements: Resources may not exceed $2,000 for an individual. Income for this track is evaluated independently from the applicant's spouse or other dependents. Additional asset disregards exist if a person is institutionalized or enrolled in the Community Choices program and has a spouse residing in the community.[10] See Table 3 for historical monthly spousal disregards.
    - Asset transfer & Home equity limit: Same as eligibility track 1a.
  - ◇ Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
  - ◇ Other requirements
    - The applicant must be receiving Medicaid Nursing Facility Care or be enrolled in a home or community-based LTC program (e.g., Community Choices program).
- 2b. Federal Poverty Level (FPL) aged and disabled
  - ◇ Income requirements: Monthly income may not exceed 100% of the FPL. In 2006, this was $817 for an individual and $1,100 for a couple. See Table 2 for historical income limits. Additional income disregards exist if a person is institutionalized or enrolled in the Community Choices program and has a spouse residing in the community.[9] See Table 3 for historical monthly spousal disregards.
  - ◇ Asset requirements: Resources may not exceed $4,000 for an individual and $6,000 for a couple.[11] Additional asset disregards exist if a person is institutionalized or enrolled in the Community Choices program and has a spouse residing in the community.[10] See Table 3 for historical monthly spousal disregards.
    - Asset transfer & Home equity limit: Same as eligibility track 1a.
  - ◇ Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
  - ◇ Other requirements
    - The applicant must be at least age 65 or disabled.[4]

Other Eligibility Tracks

There exist alternative eligibility tracks targeted at other populations. Some of these tracks include:

- Breast and Cervical Cancer Program: Provides Medicaid coverage including LTC for certain women with breast or cervical cancer

Once eligibility for Medicaid has been determined, beneficiaries may have to meet additional eligibility criteria in order to become eligible for specific LTC health benefit programs under Medicaid. Additional program criteria (if applicable) are detailed below.

Home Health Services, Nursing Facility Care

There are no additional conditions for coverage. Benefit qualification depends on minimum level of dependence (this is detailed in the *Benefit Eligibility* section of this policy period).

Community Choices

Beyond meeting minimum level of dependence requirements, applicants must be at least age 65 or age 18-64 and disabled. If the program reaches enrollment capacity, the applicant is placed on a waiting list until a spot becomes available.

Other community-based programs

There exist several home and community-based services (HCBS) programs targeted at older adults that are omitted due to limited enrollment. Some of these programs include:

- HIV/AIDS Program: Provides HCBS to individuals diagnosed with AIDS or HIV infection

- Palmetto SeniorCare: South Carolina's Program of All-Inclusive Care for the Elderly (PACE) providing medical and social services to elderly and disabled individuals in a limited number of counties throughout the state
- Mechanical Ventilator Dependent Program: Provides HCBS to elderly and disabled individuals who require mechanical ventilation
- Home Again—from 2002: Nursing home transition program under the federal Money Follows the Person initiative
- Integrated Personal Care program: Provides personal care services (PCS) to individuals residing in community residential care facilities
- South Carolina Choice program: Provides consumer-directed HCBS to individuals in a limited number of counties throughout the state

Benefit

Home care benefit

Home care benefits vary by health benefit program. The details of the 3 largest programs are summarized below.

Home Health Services

Home health provides:

- Skilled nursing services: Intermittent or part-time nursing services, such as colostomy and ileostomy care, tracheotomy aspiration, levin tube care, provided by a registered nurse or licensed practical nurse
- Home health aide services: Semi-skilled care, such as simple wound care, vital monitoring, and personal care

Home health service visits are limited to 75 visits per year until 2011 when the limit was reduced to 50 visits per year (SCDHHS, 2010).

Nursing Facility Care

Nursing facility care does not provide home care.

Community Choices

Community Choices provides (CMS, 2011; SCDHHS, 2023a):

- Personal care services (PCS): In-home assistance to recipients with housekeeping and personal care needs, such as bathing, dressing, eating, and mobility—until 2023, the PCS benefit was offered in two tiers as follows:
  - Personal Care I: Assistance with activities of daily living (ADL) such as bathing, dressing, toileting, transferring, and maintaining continence
  - Personal Care II: Assistance with instrumental ADLs (IADL) such as light housework, laundry, meal preparation, grocery shopping, and using the telephone
- Attendant care: Supportive services intended to substitute for the impairment of physical or cognitive function, including skilled or nursing care that can be provided by an attendant under the supervision of a nurse—this service is available as a consumer-directed service, meaning the individual has the option to hire and manage the schedule of the caregiver of their choice
- Companion services: Non-medical care, supervision, and socialization services provided to a functionally impaired adult—this service is available as a consumer-directed service, meaning the individual has the option to hire and manage the schedule of the caregiver of their choice

Community care

Community care benefits vary by health benefit program. The details of the 3 largest programs are summarized below.

Home Health Services, Nursing Facility Care

These programs do not provide community care.

Community Choices

Community Choices provides (CMS, 2011; SCDHHS, 2023a):

- Adult day health care (ADHC): ADHC centers provide daytime supervision, personal care assistance, and sometimes meals to recipients in a group setting
- ADHC nursing services: Skilled nursing services provided by a licensed nurse at an ADHC center
- ADHC transportation: Offered to program beneficiaries who reside within 15 miles of the ADHC center

Residential care

Residential care benefits vary by health benefit program. The details of the 3 largest programs are summarized below.

Home Health Services, Community Choices

These programs do not provide residential care.

Nursing Facility Care

South Carolina Medicaid covers residential care in a nursing facility. Care is provided 24 hours a day in a nursing facility and includes all services necessary to meet patient needs. Services may include the following (SCDHHS, 1992; SCDHHS, 2018; SCDHHS, 2023b):

- Physician services
- Room and board
- All general nursing services, including restorative nursing
- Personal hygiene care
- Medical supplies and equipment
- Rehabilitative services, including physical, speech, and occupational therapies

Other benefits

Other care benefits vary by health benefit program. Below we detail other benefits provided by Medicaid state plan benefit programs (Home Health Services, Nursing Facility Care), followed by South Carolina's largest home and community-based services (HCBS) program.

South Carolina Medicaid provides additional state plan benefits related to LTC:

- Durable medical equipment and supplies: Items that assist with an illness or injury, and may include walkers, wheelchairs, suction pumps, bandages, or similar aids —this is a required benefit under Home Health Services
- Non-emergency medical transportation: Medically necessary transportation for any recipient and personal care attendant or escort, if required, who have no other means of transportation available to any Medicaid-compensable service for the purpose of receiving treatment, medical evaluation, or therapy

Community Choices

The Community Choices program provides the following services in addition to those offered under the state plan, unless otherwise noted (CMS, 2011; SCDHHS, 2022a):

- Case management: Services that assist the participant in developing, authorizing, and monitoring the plan of care
- Home-delivered meals: Provision of at least one nutritionally sound meal per day to persons who are dependent, aged, or physically disabled and unable to care for their nutritional needs
- Respite: Services provided to participants unable to care for themselves that are furnished on a short-term basis because of the absence of or need for relief for those persons normally providing care for the participant
- Medical social services: Services provided by medical social workers intended to ease environmental, social, or situational barriers to accessing or benefiting from community-based services
- Environmental modification: Physical adaptations to the home, which are necessary to assure the health, welfare, and safety of the participant personal emergency response systems,
- Personal Emergency Response System (PERS): The installation and monitoring of electronic devices that allow enrollees at high risk of institutionalization to secure help in an emergency
- Specialized medical equipment and supplies: durable medical equipment beyond what is provided under the state plan, as well as nutritional supplements that have been prescribed by a physician as medically necessary
- Telemonitoring: Daily monitoring service that tracks the health status of at-risk program beneficiaries
- Residential personal care: Assistance with IADLs provided to program beneficiaries who live in community residential care facilities, referred to as residential personal care II to mirror the personal care II benefit as described in the *Home care benefit* section
- Nursing facility transition services—2007-2016: Up to $1,000 in one-time costs used to transition nursing facility residents to a home or community-based environment, which can include appliances, furniture, or security deposits
- Pest control—from 2022: Services to remove pests from a program beneficiary's residence required to ensure their health, safety, and welfare

Provision of care

Medicaid benefits may be provided by non-profit organizations, home health agencies, hospitals, nursing facilities, and for-profit providers, all of which are licensed and overseen by the South Carolina Department of Health and Human Services (SCDHHS). Providers that accept Medicaid payment rates and meet licensing requirements may participate in Medicaid.

Home Health Services

Skilled nursing services are provided by registered nurses, and home health aide services are provided by home health aides employed by state-certified home health agencies. Home health aide services are provided under the direction of a registered nurse (SCDHHS, 2019b).

Nursing Facility Care

Nursing facility services are provided and supervised by registered nurses and other nursing personnel of state-certified nursing facilities (SCDHHS, 2018; SCGA, 2024b § 126-425; 42 CFR 483.30).

Community Choices

Community Choices program services are provided by authorized staff of state-approved provider agencies (SCDHHS, 2019b; SCGA, 2024 § 126-425).

Benefit eligibility

Qualifying period

Potential users may apply at any time.

Minimum level of dependence

The minimum level of dependence varies by health benefit program. The details of the 3 largest programs are summarized below. Information on how level of care is assessed is detailed in the *Care Needs Assessment* section of this policy period.

Home Health Services

As required by federal law, home health services must be medically necessary and ordered by a physician. Medically necessary services are defined as those that are necessary and reasonable for the treatment of illness or injury. Until 2011 the beneficiary also had to be homebound, defined as being confined to their place of residence due to a medical or health condition. The South Carolina Department of Health and Human Services (SCDHHS) removed the homebound requirement in 2011 (SCDHHS, 2019b).

Nursing Facility Care, Community Choices

Beneficiaries must meet a nursing facility level of care (NFLOC) at either an intermediate or skilled level of care. See the *Definition of dependence* section for full eligibility criteria that define each of these dependence levels (SCDHHS, 1995; SCDHHS, 2018; SCDHHS, 2019a).

Duration of benefit

Reassessments of eligibility vary by health benefit program. Below we detail reassessments for Medicaid, followed by reassessments for the 3 largest programs.

Medicaid

Federal law requires states to renew Medicaid eligibility at least every 12 months (42 CFR 435.916).

Home Health Services

Federally mandated Medicaid recertification for home health occurs every 60 days through a physician's review of the individual's plan of care, or more often if there is a change in condition, to ensure that the services continue to be medically necessary (SCDHHS, 2019b; 42 CFR 440.70).

Nursing Facility Care, Community Choices

NFLOC must be recertified every 12 months, or with a change in condition that merits a reevaluation of the beneficiary's medical condition or functional capabilities (SCDHHS, 2018; SCDHHS, 2019a; SCDHHS, 2023a).

For recipients of nursing facility care, after admission to a nursing facility Pre-Admission Screening and Resident Review (PASRR) Level 1 Evaluations must be recertified when there is a significant change in condition, and federally required quarterly and annual Minimum Data Set (MDS) assessments must demonstrate that the resident continues to meet the criteria for skilled nursing facility care (42 CFR 483.20; 42 CFR 483.128).

Means testing

In-kind benefits are means-tested. Depending on the eligibility track used to qualify for Medicaid, the income and asset limits may differ. Means testing does not differ by health benefit program beyond the requirements used to qualify for Medicaid.

Age requirement

Age requirements vary by health benefit program. Below we detail age requirements for Medicaid, followed by age requirements for the 3 largest programs.

Medicaid

There is no age requirement for Medicaid. Age would only impact the eligibility track used to qualify for Medicaid.

Home Health Services, Nursing Facility Care

There is no age requirement.

Community Choices

The individual must be at least age 65, or 18-64 and disabled (SCDHHS, 2023a).

Care needs assessment

Definition of dependence

Definitions of dependence vary by health benefit program. The details of the 3 largest programs are summarized below.

Home Health Services

As required by federal law, home health services must be medically necessary and ordered by a physician. Medically necessary services are defined as those that are necessary for the maintenance, improvement, or protection of health or for the treatment of illness or disability. Until 2011 the beneficiary must also be homebound, defined as being confined to their place of residence due to a medical or health condition (SCDHHS, 2019b; 42 CFR 484.55).

Nursing Facility Care, Community Choices

Applicants must meet a nursing facility level of care (NFLOC). South Carolina separates NFLOC into intermediate and skilled levels of care, and individuals are eligible if they satisfy either of these levels (SCGA, 2024b §§ 126-304, 314).

To meet a skilled level of care, an individual must require at least 1 out of 11 approved skilled services listed in Box 3 and have at least 1 out of 4 functional deficits listed in Box 4. To meet an intermediate level of care, an individual must require at least 1 out of 4 approved intermediate services listed in Box 5 and 1 out of 4 functional deficits listed in Box 4, or at least 2 of the functional deficits listed in Box 4. In order to satisfy the criteria for a functional deficit, the individual must require extensive assistance with activities of daily living (ADLs) defined using the 5-point scale described in Box 6 (SCDHHS, 1995).

Evaluation of dependence

Evaluations of dependence vary by health benefit program. The details of the 3 largest programs are summarized below.

Home Health Services

A licensed physician or authorized practitioner such as a nurse or a physician assistant must order home health services in accordance with a plan of care that establishes medical need. Services must be authorized in advance, and the beneficiary must be seen by a physician at least every 60 days to recertify their continuing need for home health services (SCDHHS, 2019b).

Nursing Facility Care, Community Choices

Potential beneficiaries for both nursing facility care and Community Choices are assessed using Long Term Care Assessment Form 1718 (DHHS Form 1718). DHHS Form 1718 collects information on medical, functional, and psychobehavioral impairments, as well as environmental and demographic details in order to comprehensively assess the individuals level of care needs. The form is used to both determine whether the potential beneficiary meets the nursing facility level of care (NFLOC) requirements and to build the plan of care. For potential nursing facility residents, Form 1718 also serves as the Preadmission Screening and Resident Review (PASRR) required by the federal government to screen individuals for intellectual impairments or disabilities that may warrant specialized care in a dedicated facility, and the Minimum Data Set (MDS) is used to conduct federally mandated quarterly reviews. See Box 1 for more information on the PASRR, and Box 2 for the MDS.

The completed Form 1718 is submitted to regional offices of the SCDHHS for review along with Level of Care Certification Letter (DHHS Form 185), which certifies that the individual meets NFLOC. These certification forms must be processed prior to a beneficiary's Medicaid-covered residence in a nursing facility, or prior to the receipt of services under the Elderly and Disabled program (SCDHHS, 1995; SCDHHS, 2018; SCDHHS, 2019a).

Evaluators

Evaluators vary by health benefit program. The details of the 3 largest programs are summarized below.

Home Health Services

A licensed physician must order home health services, develop a written plan of care, and periodically review the plan of care (SCDHHS, 2019b).

Nursing Facility Care, Community Choices

A licensed physician, nurse, or social worker must certify the beneficiary's need for nursing facility care using DHHS Form 1718 (SCDHHS, 1995; SCDHHS, 2018; SCDHHS, 2019a).

Benefit limitations

Can you mix LTC benefits?

All South Carolina Medicaid beneficiaries receive the state plan benefit package. Some beneficiaries, if eligible, may also enroll in a federally approved HCBS program. Beneficiaries may not duplicate services across programs.

Is there free choice between cash and benefits in-kind?

The LTC system does not offer a cash benefit.

Can you receive LTC benefits with other public benefits?

It is possible to receive LTC benefits along with other benefits, such as SSI and Supplemental Nutrition Assistance Program (SNAP).

User costs

User charges

User charges vary by health benefit program. Below we detail user charges for Medicaid, followed by user charges for the 3 largest programs.

Medicaid

As required by federal law, South Carolina enforces Estate Recovery. The acceptance of Medicaid in South Carolina creates a debt to the state agency in the total amount paid for nursing facility care for those who are permanently institutionalized or for all nursing facility care, HCBS, and related services received after the recipient reaches 55 years of age. Upon the death of the recipient, the state agency may recover the debt by filing a statement of claim against the estate of the deceased Medicaid recipient. However, the debt will not be enforced if the recipient is survived by a spouse, child, or children under 21 years of age, or a child or children who are blind or disabled (42 USC 1396p(b)(1)).

Home Health Services

In 2011, South Carolina increased the copay for home health services from $2 to $2.30 effective April 1 (SCDHHS, 2010), and from $2.30 to $3.30 from July 11 (SCDHHS, 2011). Available South Carolina state documents do not detail policy on copayments or related charges for home health services prior to 2011. Effective July 1, 2024, South Carolina eliminated copayments for all Medicaid recipients and services (CMS, 2024).

Nursing Facility Care

Beneficiaries are expected to contribute all of their income to the cost of care in a nursing home, except for a monthly personal needs allowance (PNA) and any funds protected by the spousal impoverishment rules. See Table 3 for historical spousal impoverishment standards. In 2006, the PNA in South Carolina is $30 (SCDHHS, 2024, p. 4).

Community Choices

There are no copayments or similar charges imposed on program participants.

Taxation of benefits

In-kind benefits are not subject to taxation.

Tables and Formulas

Table 1: South Carolina Federal Medical Assistance Percentage (FMAP) for Medicaid (1992-2025)

Fiscal Year	FMAP
1992	72.66%
1993	71.28
1994	71.08
1995	70.71
1996	70.77
1997	70.43
1998	70.23
1999	69.85
2000	69.95
2001	70.44
2002	69.34
2003	71.29
2004	72.07
2005	69.89
2006	69.32
2007	69.54
2008	69.79
2009	78.96
2010	79.58
2011	75.38
2012	70.24
2013	70.43
2014	70.57
2015	70.64
2016	71.08
2017	71.30
2018	71.58
2019	71.22
2020	75.35
2021	76.83
2022	76.95
2023[1]	75.78
2024	69.91
2025	69.67

Source: U.S. DHHS (2025)

Notes: FMAPs displayed here apply to the federal fiscal year indicated unless otherwise noted, which runs from October 1 through September 30. For example, FY 2022 refers to the period from October 1, 2021 through September 30, 2022. FY 2020, FY 2021, FY 2022, and FY 2023 FMAPs reflect higher federal matching funding (6.2 percent increase in FMAP rates for all states) made available through the Families First Coronavirus Response Act for the duration of the public health emergency period (H.R. 6201).

[1]The enhanced FMAP decreased from 6.2 to 5 percentage points from April to June 2023, 2.5 percentage points from June to September 2023, and 1.5 percentage points from October to December 2023.

Table 2: South Carolina Medicaid Income Limits (1992-2025)

Year	SSI (Individual)	SSI (Couple)	300% SSI (Individual)	300% SSI (Couple)	100% FPL (Individual)	100% FPL (Couple)	100% FPL Resource Limit (Individual)	100% FPL Resource Limit (Couple)
1992	$422	$633	$1,266	$1,899	$568	$766	$4,000	$6,000
1993	434	652	1,302	1,956	581	786	4,000	6,000
1994	446	669	1,338	2,007	614	820	4,000	6,000
1995	458	687	1,374	2,061	623	836	4,000	6,000
1996	470	705	1,410	2,115	645	864	4,000	6,000
1997	484	726	1,452	2,178	658	885	4,000	6,000
1998	494	741	1,482	2,223	671	905	4,000	6,000
1999	500	751	1,500	2,253	687	922	4,000	6,000
2000	513	769	1,539	2,307	696	938	4,000	6,000
2001	531	796	1,593	2,388	716	968	4,000	6,000
2002	545	817	1,635	2,451	739	995	4,000	6,000
2003	552	829	1,656	2,487	749	1,010	4,000	6,000
2004	564	846	1,692	2,538	776	1,041	4,000	6,000
2005	579	869	1,737	2,607	798	1,070	4,000	6,000
2006	603	904	1,809	2,712	817	1,100	4,000	6,000
2007	623	934	1,869	2,802	851	1,141	4,000	6,000
2008	637	956	1,911	2,868	867	1,167	4,000	6,000
2009	674	1,011	2,022	3,033	903	1,215	4,000	6,000
2010	674	1,011	2,022	3,033	903	1,215	6,600	9,910
2011	674	1,011	2,022	3,033	908	1,226	6,680	10,020
2012	698	1,048	2,094	3,144	931	1,261	6,940	10,410
2013	710	1,066	2,130	3,198	958	1,293	7,080	10,620
2014	721	1,082	2,163	3,246	973	1,311	7,160	10,750
2015	733	1,100	2,199	3,300	981	1,328	7,160	10,750
2016	733	1,100	2,199	3,300	990	1,335	7,280	10,930
2017	735	1,103	2,205	3,309	1,005	1,354	7,390	11,090
2018	750	1,125	2,250	3,375	1,012	1,372	7,560	11,340
2019	771	1,157	2,313	3,471	1,041	1,410	7,730	11,600
2020	783	1,175	2,349	3,525	1,064	1,437	7,860	11,800
2021	794	1,191	2,382	3,573	1,074	1,452	7,970	11,960
2022	841	1,261	2,523	3,783	1,133	1,526	8,400	12,600
2023	914	1,371	2,742	4,113	1,215	1,643	9,090	13,630
2024	943	1,415	2,829	4,245	1,255	1,792	9,430	14,130
2025	967	1,450	2,901	4,350	1,325	1,783	9,660	14,470

Source: SSA (2024)

Notes: Income limits for individuals and couples are monthly.

Table 3: South Carolina Spousal Impoverishment Standards (1992-2025)

Year	Maximum MMNA	CSRA
1992	$1,718.00	$66,480
1993	1,769.00	66,480
1994	1,817.00	66,480
1995	1,870.50	66,480
1996	1,918.50	66,480
1997	1,975.50	66,480
1998	2,019.00	66,480
1999	2,049.00	66,480
2000	2,103.00	66,480
2001	2,175.00	66,480
2002	2,232.00	66,480
2003	2,267.00	66,480
2004	2,319.00	66,480
2005	2,377.50	66,480
2006	2,488.50	66,480
2007	2,541.00	66,480
2008	2,610.00	66,480
2009	2,739.00	66,480
2010	2,739.00	66,480
2011	2,739.00	66,480
2012	2,841.00	66,480
2013	2,898.00	66,480
2014	2,931.00	66,480
2015	2,980.50	66,480
2016	2,980.50	66,480
2017	3,022.50	66,480
2018	3,090.00	66,480
2019	3,160.50	66,480
2020	3,216.00	66,480
2021	3,259.50	66,480
2022	3,435.00	66,480
2023	3,715.50	66,480
2024	3,853.50	66,480
2025	3,948.50	66,480

Source: SCDHHS (1992), SCDHHS (2022b)

Notes: Federal law requires states to set the monthly maintenance needs allowance (MMNA) standard at no more than $1,500, increasing annually with inflation starting on January 1, 1990. For Community Spouse Resource Allowances (CSRAs), the maximum was set at $60,000 as of September 30, 1989, increasing each year with inflation. MMNAs and CSRAs are calculated using the Consumer Price Index for urban consumers (CPI-U).

Box 1: Preadmission Screening and Resident Review (PASRR)

Nursing facilities are required by federal law to conduct a Preadmission Screening and Resident Review (PASRR). The purpose of the PASRR is to prevent individuals with mental illness, intellectual disability, developmental disability, or a related condition from inappropriate admission to a nursing facility. The process consists of a Level I screen, Level II evaluation (depending on the outcome of the Level I screening), and a final determination. All applicants of Medicaid-certified nursing facilities receive a Level I screen to identify possible conditions. These screens generally consist of forms completed by hospital discharge planners, community health nurses, or others as defined by the state. Individuals who do or may have a mental condition as described above are referred for a Level II PASRR evaluation.

Source: 42 CFR 483.100-138

Box 2: Minimum Data Set (MDS)

Nursing facilities are required by federal law to periodically assess each resident. The Minimum Data Set (MDS) is the uniform instrument used nationally to assess resident condition. The MDS collects resident data for a variety of purposes, such as to inform care plans or assess a resident's ongoing need for nursing home care. Assessments are performed every 3 months or more often depending on the resident's health condition.

The first MDS was implemented nationally in 1991. There have been two new versions of the MDS since then —one in 1995 (MDS 2.0), and another in 2010 (MDS 3.0). However, all versions generally assess the following domains: functional and cognitive status, behavioral symptoms, diagnoses and medications, geriatric syndromes, and psychosocial functioning.

Source: CMS (2025)

Box 3: South Carolina Skilled Level of Care Criteria: Skilled Services

Beneficiaries can satisfy nursing facility level of care (NFLOC) requirements for skilled level of care by requiring 1 of the following skilled services, and by having at least 1 of the functional deficits listed in Box 4.

1. Daily monitoring/observation and assessment due to an unstable medical condition which may include overall management and evaluation of a care plan which changes daily or several times a week
2. Administration of medications which require frequent dosage adjustment, regulation, and monitoring
3. Administration of parenteral medications and fluids which require frequent dosage adjustment, regulation, and monitoring (routine injections scheduled daily or less frequently, such as insulin injection, do not qualify)
4. Special catheter care (e.g., frequent irrigation, irrigation with special medications, frequent catheterizations for specific problems)
5. Treatment of extensive decubitus ulcers or other widespread skin disorder (important considerations include: signs of infections, full thickness tissue loss, or requirement of sterile technique)
6. A single goal-directed rehabilitative service (speech, physical, or occupational therapy) by a therapist 5 days per week (combinations of therapies will satisfy this requirement)
7. Time-limited, goal-directed, educational services provided by professional or technical personnel to teach self maintenance, such as education for newly-diagnosed or acute episodic conditions (e.g., medications, treatments, procedures)
8. Nasogastric tube or gastrostomy feedings
9. Nasopharyngeal or tracheostomy aspirations or sterile tracheostomy care
10. Administration of medical gases (e.g., oxygen) for the initial phase of condition requiring such treatment, monitoring, and evaluation (generally no longer than 2 week duration)
11. Daily skilled monitoring or observation for conditions that do not ordinarily require skilled care, but because of the combination of conditions, may result in special medical complications (in these situations, the complications and the skilled services required must be documented)
12. This individual is totally dependent in all activities of daily living: incapable of locomotion; unable to transfer; totally incontinent of urinary or bowel function; must be totally bathed, dressed, toileted, and need extensive assistance to eat

Source: SCDHHS (1995)

Notes: DHHS Form 1718 determines medical eligibility for individuals applying to the Elderly and Disabled and Community Choices programs in South Carolina. Information collected is used to determine whether the individual meets nursing facility level of care (NFLOC) criteria, and to build their plan of care.

Box 4: South Carolina Skilled and Intermediate Level of Care Criteria: Functional Deficits

Beneficiaries can satisfy nursing facility level of care (NFLOC) requirements for skilled level of care by requiring 1 of the skilled services listed in Box 3, and by having at least 1 of the functional deficits listed below. Beneficiaries satisfy NFLOC requirements for intermediate level of care by requiring 1 of the intermediate services listed in Box 5 and having 1 of the functional deficits listed below, or by having at least 2 of the functional deficits listed below.

1. Requires extensive assistance (hands-on) with dressing, toileting, eating, and physical help in bathing—the applicant must require assistance with all 4 ADLs to meet this deficit
2. Requires extensive assistance (hands-on) with locomotion
3. Requires extensive assistance (hands-on) to transfer
4. Requires frequent (hands on) bladder or bowel incontinence care; or with daily catheter or ostomy care

Source: SCDHHS (1995)
Notes: DHHS Form 1718 determines medical eligibility for individuals applying to the Elderly and Disabled and Community Choices programs in South Carolina. Information collected is used to determine whether the individual meets nursing facility level of care (NFLOC) criteria, and to build their plan of care.

Box 5: South Carolina Skilled Level of Care Criteria: Intermediate Services

Beneficiaries satisfy NFLOC requirements for intermediate level of care by requiring 1 of the intermediate services listed below and having 1 of the functional deficits listed in Box 4, or by having at least 2 of the functional deficits listed in Box 4.

1. Daily monitoring of a significant medical condition requiring overall care planning in order to maintain optimum health status (the individual should manifest a documented need which warrants such monitoring)
2. Supervision of moderate/severe memory, either long or short term, manifested by disorientation, bewilderment, and forgetfulness which requires significant intervention in overall care planing
3. Supervision of moderately impaired cognitive skills manifested by decisions which may reasonably be expected to affect an individual's own safety
4. Supervision of moderate problem behavior manifested by verbal abusiveness, physical abusiveness, or socially inappropriate/disruptive behavior

Source: SCDHHS (1995)
Notes: DHHS Form 1718 determines medical eligibility for individuals applying to the Elderly and Disabled and Community Choices programs in South Carolina. Information collected is used to determine whether the individual meets nursing facility level of care (NFLOC) criteria, and to build their plan of care.

Box 6: South Carolina Skilled and Intermediate Level of Care Criteria: Impairment Scale for Functional Deficits

In order to satisfy the functional deficit criteria required to meet a nursing facility level of care, beneficiaries must require at least extensive assistance with at least 2 of the functional deficits listed in Box 4, defined using the following scale:

- Independent: The beneficiary is totally capable of completing the activity without assistance, including if they received minor assistance or supervision only 1 or 2 times over the prior 7 days
- Supervision: The beneficiary is capable of completing the activity independently with only supervision, cueing (reminders), or encouragement, including if they received limited assistance only 1 or 2 times during the prior 7 days
- Limited Assistance: The beneficiary is capable of completing the activity with only minor assistance from caregivers at least 50 percent of the time
- Extensive Assistance: The beneficiary can complete part of the activity but needs human assistance (hands-on) or verbal directions (continuous step-by-step direction) in relation to the activity 50 percent or more of the time
- Total Dependence: The beneficiary was totally unable to assist in the activity all of the prior 7 days

Source: SCDHHS (1995)
Notes: DHHS Form 1718 determines medical eligibility for individuals applying to the Elderly and Disabled and Community Choices programs in South Carolina. Information collected is used to determine whether the individual meets nursing facility level of care (NFLOC) criteria, and to build their plan of care.

Table 4: South Carolina Home Equity Limits (2006-2025)

Year	Home equity limit
2006	$500,000
2007	500,000
2008	500,000
2009	500,000
2010	500,000
2011	506,000
2012	525,000
2013	536,000
2014	543,000
2015	552,000
2016	552,000
2017	560,000
2018	572,000
2019	585,000
2020	595,000
2021	603,000
2022	636,000
2023	688,000
2024	713,000
2025	730,000

Source: GAO (2007)

Notes: The limit was $500,000 from January 2006 to December 2010, after which the equity limit began increasing annually with inflation.

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Glossary of terms

This section summarizes key definitions from the main text. To facilitate switching back and forth, this document is designed with hyperlinks. Most PDF readers have shortcuts that permit a reader to return to the previous location after selecting a hyperlink. In Adobe Acrobat on a PC: "Alt" + "←"; In Adobe Acrobat on a MAC: "command" + "←"; In Preview on a MAC: "command" + "[".

Activities of Daily Living (ADLs): Tasks performed on a daily basis that are considered necessary to live independently, including bathing or showering, dressing, toileting, eating, and transferring (mobility).

Adult Day Health Care (ADHC): ADHC is a community-based long term care benefit that provides nursing care, personal care, social, nutritional, and therapeutic services, typically furnished in a community center for four or more hours per day at least once per week.

Community Choices: South Carolina program providing home and community-based services (HCBS) to Medicaid recipients under federal 1915(c) waiver authority. In 2006 the Community Choices program replaced the Elderly and Disabled program, combining it with a recently implemented program called SC Choice which piloted consumer-directed HCBS in a limited number of counties throughout the state.

Community Spouse Resource Allowance (CSRA): Upper limit on countable assets for a spouse residing in the community if their spouse is institutionalized or requires home and community-based long-term care.

Companion care: Companion care services provide care, supervision, and socialization to functionally impaired beneficiaries of the Community Choices program. This benefit emphasizes supervision over the provision of hands-on care.

Consumer-directed services: Service provision allowing program beneficiaries to exercise greater control over their care by allowing them to hire caregivers of their own choosing, which can often include family and friends.

Copayment: A fixed amount the beneficiary will pay for a covered health care service after they have paid their deductible.

Deficit Reduction Act of 2005: Federal legislation that established home equity limits and increased the look back period for all assets. South Carolina implemented a home equity limit of $500,000 beginning in 2006. From 2011, this amount increased annually with inflation. From 2006, the look-back period is 60 months for all assets.

Elderly and Disabled program: South Carolina program providing home and community-based services (HCBS) to a limited number of Medicaid recipients age 65 and over 18 with a disability under federal 1915(c) waiver authority.

Eligibility Track 1a. Supplemental Security Income (SSI) Recipients: Mandatory coverage group under Medicaid that automatically guarantees Medicaid coverage to individuals that receive SSI, a federal cash assistance benefit for aged, blind, and disabled individuals with limited means.

Eligibility Track 2a. Institutional Rules for People Receiving LTC: Optional coverage group under Medicaid that allows for expanded income limits, up to 300 percent of the federal poverty level, for individuals that are in an institution or who medically qualify for placement in an institution and are instead receiving home and community-based services (HCBS). Federal terminology separates the institutional and HCBS populations into two coverage groups: Individuals receiving HCBS under Institutional Rules, and Institutional Individuals Eligible under a Special Income Level. This is because some states do not extend this income limit to both coverage groups. For ease, we have combined the two groups under a single track, as regardless of whether it applies only to institutional care or extends to HCBS, the eligibility track uses institutional standards, e.g., institutional income/asset limits including spousal impoverishment disregards, as well as dependence requirements (NFLOC). In the relatively rare instance where this track applies to HCBS recipients only, eligibility is granted based on whether an individual would be eligible if institutionalized and institutional rules still apply. It will be clearly noted in policy documents when a state does not extend this income limit to both populations.

Eligibility Track 2b. Federal Poverty Level (FPL) Aged and Disabled: Optional coverage group under Medicaid that allows for expanded income limits up to 100 percent of the federal poverty level for individuals who are at least age 65, blind, or disabled.

Eligibility Tracks: Requirements for an individual to qualify for Medicaid and start receiving long-term care benefits. An individual typically must satisfy only one eligibility track to qualify for Medicaid.

Estate Recovery: State Medicaid programs must recover certain Medicaid benefits paid on behalf of a Medicaid enrollee. For individuals age 55 or older, states are required to seek recovery of payments from the individual's estate for nursing facility services, home and

community-based services, and related hospital and prescription drug services. States may not recover from the estate of a deceased Medicaid enrollee who is survived by a spouse, child under age 21, or blind or disabled child of any age.

Federal Medical Assistance Percentage (FMAP): The percentage of Medicaid payments that the federal government pays as a share of both federal and state government payments for Medicaid services. The FMAP is computed from a formula that takes into account the average per capita income for each State relative to the national average. The minimum FMAP is 50 percent.

Federal Poverty Level (FPL): Poverty threshold established by the Department of Health and Human Services (HHS) for administrative purposes, such as determining financial eligibility for federal programs. The Federal Poverty Level (FPL) is determined annually for different household sizes and financial eligibility for a program is generally a percentage of the FPL (e.g., 100 percent of the FPL), meaning households with annual/monthly income at or below 100 percent of the FPL would qualify based on financial eligibility.

Home Health Aide Services: Home health aides assist with personal care as well as some semi-skilled tasks, such as observing vital signs, administering medication under the direction of a nurse, and more.

Home Health Services: Services provided in the patient's home to promote, maintain, or restore health or lessen the effects of illness and disability. Services may include part-time or intermittent nursing care, speech, physical and occupational therapies, and home health aide services (personal care and semi-skilled tasks such as ostomy care). This service also includes medical equipment and supplies if medically necessary.

Home and Community-Based Services (HCBS): Services designed to assist individuals in a home or community setting, such as an adult day center. HCBS are often designed to enable people to stay in their homes in lieu of nursing home admission.

Homebound: An individual is considered homebound if they have a condition due to illness or injury that makes leaving the home medically inadvisable.

Instrumental Activities of Daily Living (IADLs): Tasks related to independent living including preparing meals, managing money, shopping for groceries, performing housework, and using a telephone.

Intermediate level of care: The minimum dependence level required to meet a nursing facility level of care (NFLOC) in South Carolina. To meet an intermediate level of care individuals must have at least two functional deficits, or have one functional deficit along with documented medical need for at least one intermediate service such as daily monitoring of a significant medical condition or supervision needed to manage memory, cognitive, or behavioral issues.

Level of Care Certification Letter (DHHS Form 185): Form used to certify that individuals seeking access to nursing facility care or home and community-based services meet the nursing facility level of care (NFLOC) requirements for program entry.

Long Term Care Assessment Form 1918 (DHHS Form 1718): Comprehensive assessment used to evaluate and periodically reevaluate beneficiaries of nursing facility care as well as home and community-based services (HCBS) under the Elderly and Disabled and Community Choices programs.

Mandatory Categorically Needy: An eligibility track that states are required to cover under Medicaid. This track encompasses several categorical groups, including individuals receiving SSI, pregnant women, and some children.

Medicaid state plan: Every state has a Medicaid State Plan, a comprehensive document that outlines the amount, scope, and duration of all services offered under the State's standard benefit package. All beneficiaries may receive all services in the standard benefit package (e.g., personal care, home health), however, benefit programs may have varying eligibility criteria (e.g., level of dependence). If eligible, some beneficiaries may enroll in an HCBS program. HCBS program enrollees may receive all state plan benefits as well as additional services under the program. If a beneficiary is enrolled in managed care, they may receive all state plan benefits through their managed care plan and may receive additional benefits as available.

Medically necessary: As defined by the U.S. Department of Health and Human Services, medically necessary services are health care services or supplies needed to diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine. This is usually the dependence threshold that must be met to receive a Medicaid benefit. However, the exact dependence characteristics needed to meet this threshold vary by state, although it usually is met through a physician's order for services.

Minimum Data Set (MDS): A federally mandated tool for implementing standardized assessment and for facilitating care management in nursing homes.

Money Follows the Person: Federal Medicaid program that provides transition support services for nursing home residents who wish to receive care in a home or community-based setting.

Monthly Maintenance Needs Allowance (MMNA): Amount of countable income for a beneficiary's spouse residing in the community if the beneficiary is institutionalized or requires home and community-based long-term care.

Nursing facility care: Residential care that typically provides skilled nursing or medical care and related services, rehabilitation needed due to injury, disability, or illness, and health-related care and services (above the level of room and board) not available in the community, needed regularly due to a mental or physical condition.

Nursing Facility Level of Care (NFLOC): Level of care comparable to what an individual would receive in a nursing facility. This is often the minimum level of dependence required for long-term care programs.

Optional Categorically Needy: An eligibility track that states may opt in to cover. This track encompasses several groups, including aged and disabled individuals not receiving SSI, some individuals receiving long-term care.

Other populations: The Gateway Policy Explorer Long-Term Care Series is primarily focused on individuals most likely to require long-term care, such as older adults or disabled individuals. There are additional eligibility tracks one may use to qualify for Medicaid that are out-of-scope for this Series. Some of these include pregnant women, children, and families with children.

Program of All-Inclusive Care for the Elderly (PACE): A federally authorized program that provides comprehensive medical and social services to elderly individuals requiring a nursing facility level of care. PACE programs are typically provided under Medicare, however states can elect to provide PACE services to Medicaid beneficiaries as an optional benefit. Enrollment in PACE programs is typically capped at a relatively low number of participants.

Permanently Residing Under Color of Law (PRUCOL): An immigration status where Immigration and Naturalization Services knows of and permits the individual's presence in the country and does not contemplate enforcing their departure. Oftentimes, this status is for refugees or parolees.

Personal Care Services: Medicaid optional state plan benefit that provides in-home assistance to recipients with housekeeping and personal care needs, such as bathing, dressing, eating, and mobility.

Personal Emergency Response System (PERS): Electronic devices (e.g., portable "help" buttons connected to the Enrollee's telephone and monitored by response centers) that enable beneficiaries who are alone for significant parts of the day and who would otherwise require extensive routine supervision to secure help in an emergency.

Personal Needs Allowance: Income that is exempt from contribution to nursing home cost that may be spent on any personal item by institutionalized beneficiaries.

Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996: Federal legislation that restricted most legal immigrants entering the United States after August 22, 1996, from receiving federally funded Medicaid or Supplemental Security Income (SSI) for at least five years after immigration or until they attain citizenship.

Preadmission Screening and Resident Review (PASRR): A federally required assessment for nursing facility applicants to ensure that individuals are not inappropriately placed in nursing homes for long term care. The initial Level I assessment screens for mental illnesses or other related conditions. If the Level I assessment indicates that the applicant has a mental illness or related condition, they will be directed to a Level II assessment and alternative residential care.

Prior authorization: An approval that is sometimes required before a service may be provided. Specifically, prior authorization is a determination by a utilization review entity that a covered service has been reviewed and, based on the information provided, satisfies the utilization review entity's requirements for medical necessity and appropriateness and that payment will be made for that health care service.

Qualified Income Trust (QIT): A Qualified Income Trust (QIT), or Miller Trust, is an irrevocable trust that allows individuals with excess income to qualify for Medicaid benefits under eligibility track 2a (Institutional rules). Each month, the beneficiary's excess income is deposited in the QIT, and a designated trustee can use these funds for limited purposes that include the beneficiary's monthly personal needs allowance, residential care facility costs, community spouse allocations, and any other care-related expenses. When the beneficiary passes away, any remaining funds in the account are claimed by the State.

Respite care: Services provided to participants who are unable to care for themselves, furnished on a short-term basis because of the absence or need of relief for those persons normally providing care for the participant.

SC Choice: South Carolina program that provided consumer-directed home and community-based services (HCBS) between 2003-2006, before being combined with the Eldelry and Disabled program to create a new Community Choices program offering both traditional as well as consumer-directed HCBS. SC Choice was initially offered in three counties (Spartanburg, Cherokee, and Union counties) before being expanded state-wide, however enrollment was capped at relatively low numbers until the program was folded into the Community Choices program in 2006.

Skilled level of care: One of two dependence levels required to meet a nursing facility level of care (NFLOC) in South Carolina. To meet a skilled level of care an individual must have at least one functional deficit and must require at least one skilled service, defined as a service that must be ordered by a physician and administered by skilled personnel.

Skilled Nursing Services: Skilled nursing care consists of those services that must, under State law, be performed by or under the supervision of a licensed or certified nurse. These services include injections, tube feedings, catheter changes, observation and assessment of a patient's conditions, and more.

Social Security Disability Insurance (SSDI) : Federal program providing cash assistance to Americans with disabilities and qualifying work history, as determined by the Social Security Administration.

South Carolina Department of Health and Human Services: State agency responsible for administering and overseeing South Carolina's Medicaid program.

State Supplemental Payment (SSP): Monthly cash payments offered by states to low-income individuals in addition to Supplemental Security Income (SSI). States offering optional SSPs may do so to account for higher costs of living or as an additional income disregard for individuals in certain living arrangements (e.g., nursing facility). In South Carolina, the SSP provides provides additional financial assistance to elderly and disabled residents of community residential care facilities.

Supplemental Nutritional Assistance Program (SNAP): Federal nutrition assistance program that provides benefits to eligible low-income individuals and families via an Electronic Benefits Transfer card. This card can be used like a debit card to purchase eligible food in authorized retail food stores.

Supplemental Security Income (SSI): The U.S. old-age cash assistance program for aged, blind, and disabled persons of limited means.

Notes

This section reports notes from the main text. To facilitate switching back and forth, this document is designed with hyperlinks. Most PDF readers have shortcuts that permit a reader to return to the previous location after selecting a hyperlink. In Adobe Acrobat on a PC: "Alt" + "←"; In Adobe Acrobat on a MAC: "command" + "←"; In Preview on a MAC: "command" + "[".

1. SSI recipients in some states receive a State Supplementary Payment (SSP). In South Carolina, the SSP provides provides additional financial assistance to elderly and disabled residents of community residential care facilities.
2. In 1992 the look back period was 30 months prior to the date of application for all assets. In 1993 the look back period was extended to 36 months for assets, except in the case of a trust treated as a transfer in which case the look back period was 60 months prior to the date of application. Although an individual's home is generally not a countable resource, for this purpose it is considered a resource and subject to transfer prohibitions unless it is transferred to the individual's spouse, minor or disabled child, or, in some circumstances, sibling or adult child (KFF, 1999).
3. Lawfully permanent residents and PRUCOL (i.e., Immigration and Naturalization Services knows of a nd permits their presence in the country and does not contemplate enforcing their departure, oftentimes refugees or parolees).
4. Applicants must meet strict requirements established by the Social Security Administration in order to qualify for SSI through a disability or blindness. See SSA (2024) for more information on these requirements.
5. Spousal considerations for income: If a beneficiary is institutionalized (e.g., resides in a nursing home) and their spouse resides in the community, there are spousal impoverishment laws that allow the community spouse to retain countable income and assets up to a certain amount. The community spouse is allowed to keep up to a maximum Monthly Maintenance Needs Allowance

(MMNA) and can allocate from the institutionalized spouse's income up to the MMNA as the community spouse's income. In 1992, the MMNA in South Carolina was $1,718 per month (SCDHHS, 1992).

6. Spousal considerations for assets: The community spouse is also able to keep 100% of the couple's countable assets up to the maximum federal Community Spouse Resource Allowance (CSRA), which was $66,480 in 1992 (SCDHHS, 1992). Countable assets/property are real and personal property that are counted to determine eligibility.
7. In 2006 the Deficit Reduction Act extended the look back period to 60 months for all assets. Although an individual's home is generally not a countable resource, for this purpose it is considered a resource and subject to transfer prohibitions unless it is transferred to the individual's spouse, minor or disabled child, or, in some circumstances, sibling or adult child (KFF, 1999).
8. The equity value is derived by subtracting any legal encumbrances (e.g., liens, mortgages) from the fair market value of the home. Exceptions exist if the person's spouse, child, or adult child with a disability is living in the home.
9. Spousal considerations for income: If a beneficiary is institutionalized (e.g., resides in a nursing home) and their spouse resides in the community, there are spousal impoverishment laws that allow the community spouse to retain countable income and assets up to a certain amount. The community spouse is allowed to keep up to a maximum Monthly Maintenance Needs Allowance (MMNA) and can allocate from the institutionalized spouse's income up to the MMNA as the community spouse's income. In 2006, the MMNA in South Carolina was $2,488.50 per month.
10. Spousal considerations for assets: The community spouse is also able to keep 100% of the couple's countable assets up to the maximum federal Community Spouse Resource Allowance (CSRA), which was $66,480 in 2006. Countable assets/property are real and personal property that are counted to determine eligibility.
11. South Carolina uses standards from the Federal Qualified Medicare Beneficiaries program for its eligibility track 2b (Federal Poverty Level Aged Blind and Disabled) asset limits. These were $4,000 for an individual and $6,000 for a couple until 2010 when the Medicare Improvements for Patients and Providers Act increased the asset limits to $6,600 for an individual and $9,910 for a couple and mandated annual increases with inflation.

Version information

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Version History

- 1.0 (April 2025): First version.