

APPENDIX K: Emergency Preparedness and Response and COVID-19 Addendum

Background:

This standalone appendix may be utilized by the state during emergency situations to request amendments to its approved waiver, to multiple approved waivers in the state, and/or to all approved waivers in the state. It includes actions that states can take under the existing Section 1915(c) home and community-based waiver authority in order to respond to an emergency. Other activities may require the use of various other authorities such as the Section 1115 demonstrations or the Section 1135 authorities.¹ This appendix may be applied retroactively as needed by the state. Public notice requirements normally applicable under 1915(c) do not apply to information contained in this Appendix.

Appendix K-1: General Information

General Information:

A. State: South Carolina

B. Waiver Title(s): Intellectually Disabled and Related Disabilities Waiver (ID/RD), Community Supports (CS), Head and Spinal Cord Injury (HASCI), Community Choices (CC), HIV/AIDS, and Mechanical Ventilator Dependent (VENT)

C. Control Number(s): ID/RD: SC.0237.R05.04
CS: SC.0676.R02.04
HASCI: SC.0284.R05.03
CC: 0405.R03.02
HIV/AIDS: 0186.R06.02
VENT: 40181.R05.02

D. Type of Emergency (The state may check more than one box):

<input checked="" type="checkbox"/>	Pandemic or Epidemic
<input type="checkbox"/>	Natural Disaster
<input type="checkbox"/>	National Security Emergency
<input type="checkbox"/>	Environmental
<input type="checkbox"/>	Other (specify):

E. Brief Description of Emergency. *In no more than one paragraph each*, briefly describe the: 1) nature of emergency; 2) number of individuals affected and the state's mechanism to identify individuals at risk; 3) roles of state, local and other entities involved in approved waiver operations; and 4) expected changes needed to service delivery methods, if applicable. The state should provide this information for each emergency checked if those emergencies affect different geographic areas and require different changes to the waiver.

COVID-19 pandemic. This amendment will apply waiver-wide for each waiver included in this Appendix, to all individuals impacted by the virus or the response to the virus (e.g. closure of day programs, etc.) This amendment is additive to the Appendix K approved on April 21, 2020. With this amendment, the state is modifying the scope of service for the Adult Day Health Care (ADHC) service; adding retainer payments, with up to three episodes with guardrails, and requesting flexibilities in the 372 and evidence reporting.

F. Proposed Effective Date: Start Date: January 27, 2020 **Anticipated End Date:** January 26, 2021

G. Description of Transition Plan.

All activities will take place in response to the impact of COVID-19 as efficiently and effectively as possible based upon the complexity of the change.

H. Geographic Areas Affected:

These actions will apply across the waiver to all individuals impacted by the COVID-19 virus.

I. Description of State Disaster Plan (if available) Reference to external documents is acceptable:

CC, HIV/AIDS and VENT programs have a "Disaster Preparedness Manual" that details processes in the event of natural disasters (e.g., hurricanes, floods etc.). Additionally, the State follows any mandates from the State's Emergency Management Division (SCEMD) as well as the State's Department of Health and Environmental Control (SCDHEC).

The South Carolina Department of Disabilities and Special Needs (SCDDSN) maintains a Disaster Preparedness Plan (SCDDSN Disaster Preparedness Plan) on its website as well as agency directive for each SCDDSN facility and DSN provider to maintain a disaster plan.

Appendix K-2: Temporary or Emergency-Specific Amendment to Approved Waiver

Temporary or Emergency-Specific Amendment to Approved Waiver:

These are changes that, while directly related to the state's response to an emergency situation, require amendment to the approved waiver document. These changes are time limited and tied specifically to individuals impacted by the emergency. Permanent or long-ranging changes will

need to be incorporated into the main appendices of the waiver, via an amendment request in the waiver management system (WMS) upon advice from CMS.

a. ___ Access and Eligibility:

i. ___ Temporarily increase the cost limits for entry into the waiver.

[Provide explanation of changes and specify the temporary cost limit.]

ii. ___ Temporarily modify additional targeting criteria.

[Explanation of changes]

b. X Services

i. X Temporarily modify service scope or coverage.

[Complete Section A- Services to be Added/Modified During an Emergency.]

ii. X Temporarily exceed service limitations (including limits on sets of services as described in Appendix C-4) or requirements for amount, duration, and prior authorization to address health and welfare issues presented by the emergency.

[Explanation of changes]

ID/RD, CS and CC:
Temporarily suspend the requirement for the Adult Day Health Care (ADHC) service to consist of a minimum of five (5) hours per day.

iii. ___ Temporarily add services to the waiver to address the emergency situation (for example, emergency counseling; heightened case management to address emergency needs; emergency medical supplies and equipment; individually directed goods and services; ancillary services to establish temporary residences for dislocated waiver enrollees; necessary technology; emergency evacuation transportation outside of the scope of non-emergency transportation or transportation already provided through the waiver).

[Complete Section A-Services to be Added/Modified During an Emergency]

iv. Temporarily expand setting(s) where services may be provided (e.g. hotels, shelters, schools, churches). Note for respite services only, the state should indicate any facility-based settings and indicate whether room and board is included:

[Explanation of modification, and advisement if room and board is included in the respite rate]:

v. ___ Temporarily provide services in out of state settings (if not already permitted in the state's approved waiver). [Explanation of changes]

c. ___ Temporarily permit payment for services rendered by family caregivers or legally responsible individuals if not already permitted under the waiver. Indicate the services to which this will apply and the safeguards to ensure that individuals receive necessary services as authorized in the plan of care, and the procedures that are used to ensure that payments are made for services rendered.

d. ___ Temporarily modify provider qualifications (for example, expand provider pool, temporarily modify or suspend licensure and certification requirements).

i. ___ Temporarily modify provider qualifications.

[Provide explanation of changes, list each service affected, list the provider type, and the changes in provider qualifications.]

ii. ___ Temporarily modify provider types.

[Provide explanation of changes, list each service affected, and the changes in the provider type for each service].

iii. ___ Temporarily modify licensure or other requirements for settings where waiver services are furnished.

[Provide explanation of changes, description of facilities to be utilized and list each service provided in each facility utilized.]

e. ___ Temporarily modify processes for level of care evaluations or re-evaluations (within regulatory requirements). [Describe]

f. ___ Temporarily increase payment rates.

[Provide an explanation for the increase. List the provider types, rates by service, and specify whether this change is based on a rate development method that is different from the current approved waiver (and if different, specify and explain the rate development method). If the rate varies by provider, list the rate by service and by provider.]

g. ___ Temporarily modify person-centered service plan development process and individual(s) responsible for person-centered service plan development, including qualifications.

[Describe any modifications including qualifications of individuals responsible for service plan development, and address Participant Safeguards. Also include strategies to ensure that services are received as authorized.]

h. ___ Temporarily modify incident reporting requirements, medication management or other participant safeguards to ensure individual health and welfare, and to account for emergency circumstances. [Explanation of changes]

i. ___ Temporarily allow for payment for services for the purpose of supporting waiver participants in an acute care hospital or short-term institutional stay when necessary supports (including communication and intensive personal care) are not available in that setting, or when the individual requires those services for communication and behavioral stabilization, and such services are not covered in such settings.

[Specify the services.]

j. X Temporarily include retainer payments to address emergency related issues.

[Describe the circumstances under which such payments are authorized and applicable limits on their duration. Retainer payments are available for habilitation and personal care only.]

The state will implement retainer payments for each of the following individual services which include personal care services.

- Adult Day Health Care
- Adult Day Health Care Nursing
- Attendant Care
- Personal Care I and II
- Agency Companion
- Respite
- Nursing (RN, LPN, Medicaid Nursing, Children's Private Duty Nursing)
- Day Activity
- Career Preparation
- Community Services
- Support Center Services
- Group Employment
- Individual Employment

The retainer payments will be offered to providers when individual beneficiaries may not receive services in response to the state of emergency resulting from self-care, self-quarantine, COVID diagnosis, or when providers are unable to render services because of COVID emergency response. The retainer payments will be offered for three episodes of up to 30 consecutive billing days, with service categories divided into two groups.

Service Group 1: Services offered on a week-day schedule leading to five service days billable per week (leading to 30 days over six weeks) will be calculated for the following intervals: March 16, 2020 to April 24, 2020, April 27, 2020 to June 5, 2020 and June 8, 2020 to July 17, 2020, respectively. The services eligible for payments under group one are:

- Adult Day Health Care;
- Adult Day Health Care Nursing;
- Day Activity;
- Career Preparation;
- Community Services;
- Support Center Services;
- Group Employment; and
- Individual Employment.

Service Group 2: Services typically offered on a seven-day week schedule leading to seven billable service days per week, or 30 billable service days per 30 calendar days will be calculated for the following intervals: March 16, 2020 to April 14, 2020; April 15, 2020 to May 14, 2020; and May 15, 2020 to June 13, 2020. The services eligible for this group are:

- Attendant Care;
- Personal Care I and II;
- Agency Companion;
- Respite; and

- Nursing

Providers offering multiple service types to beneficiaries may not receive retainer payments for one service when an individual elects to change service type or location, such as if a beneficiary foregoes Adult Day Health Care and instead receives in-home personal care. The methodology will not factor in payments for individuals that exceed 30 consecutive eligible billing cycle days.

Given the pervasive nature of service delivery interruption during the COVID emergency, retainer payments will be made based upon the average payment amount made to providers on an incurred basis over the retrospective eight-month period preceding the state-declared state of emergency in March 2020. Adjustments may be made to these payments based upon service delivery outliers or new market entrants over this period. Providers must demonstrate sufficient service interruption equivalent to a 10% decrease of service activity, as measured by total payment, or \$1,000 equivalent for each period, whichever is greater to be eligible for the payments. The amount of the payment will be 40% of the difference between actual service revenue based on services delivered and the calculated average to ensure that providers are not compensated for deferred costs associated with furloughed or laid-off staff or receive redundant compensation resulting from other state of federal provider relief payments. Providers will receive 100% of the payments, regardless of the waiver's operating agency.

The state will implement a series of safeguards to monitor payments to avoid duplication of billing and to monitor the use of retainer payments, including:

- Providers must attest that all claims for actual services rendered during the period are submitted and adjudicated. The attestation requirements and timing of analysis and payments for each episode will be established based on a determined claims run-out period (45-day run out OR 6-month claims run out).
- Providers must be currently enrolled in the program and must have been enrolled on Jan 1, 2020 and in good standing.
- Providers must have billings in the three (3) months prior to the COVID-19 public health emergency.
- The Agency will require an attestation from the provider that all of the revenue received from COVID-19 related sources such as SBA, FEMA, provider relief funds, state-specific relief funds and retainer payments combined will not exceed normal revenues as calculated by the prior run out period or quarter period prior to the PHE. Attestation will include that they had not received funding from any other sources, including but not limited to unemployment benefits and Small Business Administration loans, that would exceed their revenue for the last full quarter prior to the PHE, or that the retainer payments at the level provided by the state would not result in their revenue exceeding that of the quarter prior to the PHE.
- The Agency will require an attestation from the provider that it will not lay off staff, and will maintain wages at existing levels.

- The Agency will conduct post payment review for billed claims after 12 months has elapsed. The state will collect an attestation from the provider acknowledging that retainer payments will be subject to recoupment if inappropriate billing or duplicate payments for services occurred or duplicate uses of available funding streams, as identified in a state or federal audit or any other authorized third party review.

k. ___ Temporarily institute or expand opportunities for self-direction.

[Provide an overview and any expansion of self-direction opportunities including a list of services that may be self-directed and an overview of participant safeguards.]

l. ___ Increase Factor C.

[Explain the reason for the increase and list the current approved Factor C as well as the proposed revised Factor C]

m. __X_ Other Changes Necessary [For example, any changes to billing processes, use of contracted entities or any other changes needed by the State to address imminent needs of individuals in the waiver program]. [Explanation of changes]

The timeframes for the submission of the CMS 372s and the evidentiary package(s) will be extended as needed pursuant to the emergency. In addition, the state may suspend the collection of data for performance measures other than those identified for the Health and Welfare assurance and notes that as a result the data will be unavailable for this time frame in ensuing reports due to the circumstances of the pandemic.

Appendix K Addendum: COVID-19 Pandemic Response

1. HCBS Regulations

- a. Not comply with the HCBS settings requirement at 42 CFR 441.301(c)(4)(vi)(D) that individuals are able to have visitors of their choosing at any time, for settings added after March 17, 2014, to minimize the spread of infection during the COVID-19 pandemic.

2. Services

- a. Add an electronic method of service delivery (e.g., telephonic) allowing services to continue to be provided remotely in the home setting for:
 - i. Case management
 - ii. Personal care services that only require verbal cueing
 - iii. In-home habilitation
 - iv. Monthly monitoring (i.e., in order to meet the reasonable indication of need for services requirement in 1915(c) waivers).
 - v. Other *[Describe]*:

- b. Add home-delivered meals
- c. Add medical supplies, equipment and appliances (over and above that which is in the state plan)
- d. Add Assistive Technology

3. Conflict of Interest: The state is responding to the COVID-19 pandemic personnel crisis by authorizing case management entities to provide direct services. Therefore, the case management entity qualifies under 42 CFR 441.301(c)(1)(vi) as the only willing and qualified entity.

- a. Current safeguards authorized in the approved waiver will apply to these entities.
- b. Additional safeguards listed below will apply to these entities.

4. Provider Qualifications

- a. Allow spouses and parents of minor children to provide personal care services
- b. Allow a family member to be paid to render services to an individual.
- c. Allow other practitioners in lieu of approved providers within the waiver. *[Indicate the providers and their qualifications]*

- d. Modify service providers for home-delivered meals to allow for additional providers, including non-traditional providers.

5. Processes

- a. Allow an extension for reassessments and reevaluations for up to one year past the due date.
- b. Allow the option to conduct evaluations, assessments, and person-centered service planning meetings virtually/remotely in lieu of face-to-face meetings.
- c. Adjust prior approval/authorization elements approved in waiver.

- d. Adjust assessment requirements
- e. Add an electronic method of signing off on required documents such as the person-centered service plan.

Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the request:

First Name: Nicole
Last Name Mitchell Threatt
Title: Program Manager II
Agency: South Carolina Department of Health and Human Services
Address 1: 1801 Main St.
Address 2: Click or tap here to enter text.
City Columbia
State SC
Zip Code 29201
Telephone: (803)898-2689; (803)315-6780 (cell)
E-mail Mitcheln@scdhhs.gov
Fax Number Click or tap here to enter text.

B. If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

First Name: Click or tap here to enter text.
Last Name Click or tap here to enter text.
Title: Click or tap here to enter text.
Agency: Click or tap here to enter text.
Address 1: Click or tap here to enter text.
Address 2: Click or tap here to enter text.
City Click or tap here to enter text.
State Click or tap here to enter text.
Zip Code Click or tap here to enter text.
Telephone: Click or tap here to enter text.
E-mail Click or tap here to enter text.
Fax Number Click or tap here to enter text.

8. Authorizing Signature

Signature:

Date: 7/16/2020

_____/S/_____
State Medicaid Director or Designee

First Name: Joshua
Last Name Baker
Title: State Medicaid Director
Agency: South Carolina Department of Health and Human Services
Address 1: 1801 Main St.
Address 2: Click or tap here to enter text.
City Columbia
State SC
Zip Code 29201
Telephone: (803)898-2504
E-mail Joshua.baker@scdhhs.gov
Fax Number Click or tap here to enter text.

Section A---Services to be Added/Modified During an Emergency

Complete for each service added during a time of emergency. For services in the approved waiver that the state is temporarily modifying, enter the entire service definition and highlight the change. State laws, regulations and policies referenced in the specification should be readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification

Service Title: Adult Day Health Care

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

Service Definition (Scope):

Services generally furnished on a regularly scheduled basis, for one or more days per week, or as specified in the service plan, in a licensed non-institutional, community-based setting encompassing both health and social services needed to ensure the optimal functioning of the participant. This includes off-site outings and other efforts designed to provide socialization and integrate participants into the community. Meals provided as a part of these services shall not constitute a "full nutritional regime" (3 meals per day).

Removed from service definition (scope): Services furnished 5 or more hours per day.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

A minimum of one hour at the center is required. Reimbursement cannot exceed the daily rate of \$56.40.

Provider Specifications

Provider Category(s) (check one or both):	<input type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/>	Agency. List the types of agencies:
				Adult Day Health Care Centers

Specify whether the service may be provided by (check each that applies):	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>	Relative/Legal Guardian
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Provider Qualifications (provide the following information for each type of provider):


Provider Type:	License (specify)	Certificate (specify)	Other Standard (specify)
Adult Day Health Care Centers	Yes, Code of Laws 40-33-10 et. seq		

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Adult Day Health Care Centers	Department of Health and Human Services	Upon enrollment and at least once every 18-24 months

Service Delivery Method

Service Delivery Method (check each that applies):	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/>	Provider managed



ⁱ Numerous changes that the state may want to make may necessitate authority outside of the scope of section 1915(c) authority. States interested in changes to administrative claiming or changes that require section 1115 or section 1135 authority should engage CMS in a discussion as soon as possible. Some examples may include: (a) changes to administrative activities, such as the establishment of a hotline; or (b) suspension of general Medicaid rules that are not addressed under section 1915(c) such as payment rules or eligibility rules or suspension of provisions of section 1902(a) to which 1915(c) is typically bound.