SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

HOME AND COMMUNITY-BASED SERVICES (HCBS) PROVIDER MANUAL

July 1, 2025

South Carolina Department of Health and Human Services

CONTENTS

1
PROGRAM OVERVIEW

PROGRAM DESCRIPTION

The South Carolina Department of Health and Human Services (SCDHHS) oversees the provision of Home and Community-Based Services (HCBS) delivered to eligible participants with long term care needs, if they choose, allowing them to remain in a community-based environment. The South Carolina Department of Health and Human Services (SCDHHS) administers and operates several 1915(c) HCBS waiver programs: Community Choices waiver (CC); HIV/AIDS waiver; Medically Complex Children's waiver (MCC), and Mechanical Ventilator Dependent waiver (Vent). SCDHHS also administers the following state plan programs/services: Children's Personal Care (CPC), Private Duty Nursing (PDN)., and Program for All-Inclusive Care for the Elderly (PACE). All 1915(c) waivers and state plan services are operated pursuant to the Code of Federal Regulations (CFR).

SCDHHS retains administrative authority for the following waivers: Head and Spinal Cord Injury (HASCI), Intellectual Disability/Related Disabilities (ID/RD), and Community Supports (CS). SCDHHS has delegated operational authority to the South Carolina Department of Disabilities and Special Needs (SCDDSN) for operation of these waivers.

SCDHHS retains administrative authority for the Palmetto Coordinated System of Care (PCSC) waiver. SCDHHS has delegated operational authority to the South Carolina Continuum of Care for operation of this waiver.

SCDHHS also operates South Carolina's Money Follows the Person grant (Home Again).

HCBS waiver programs allow participants who meet an institutional level of care to receive services and supports not covered through the South Carolina Medicaid State Plan. These services and supports are provided through the waiver programs to assist participants in remaining in their own home or other community setting. Pursuant to 42 CFR 441.301(a)(3), the state refuses entrance to the waiver to any otherwise eligible participant when the state reasonably expects that the cost of the home and community-based services furnished to that participant would exceed 100% of the cost of the level of care specified for the waiver, or for the CS waiver when the state reasonably expects that the cost of home and community-based services furnished to that individual would exceed the amount specified by the state that is less than the cost of a level of care specified for the waiver. The HCBS Provider Manual is complementary to SCDHHS's policies and procedures detailed in the Provider Administrative and Billing Manual.

HCBS providers must review, reference, and comply with the HCBS Provider Manual, the Administrative and Billing Manual, and all appendices and supplements.

SCDHHS Operated Waivers

Community Choices (CC) Waiver

The Community Choices (CC) waiver is designed to serve Medicaid-eligible participants who are aged eighteen (18) or older, have long term care needs and meet nursing home level of care. To avoid or delay costly nursing home admission, participants can access the services necessary to receive care at home through careful assessment, service planning, care coordination and monitoring.

HIV/AIDS Waiver

The Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) waiver is designed to serve Medicaid-eligible participants with HIV/AIDS, regardless of age, who choose to live at home but have long term care needs and are at risk for hospitalization.

Mechanical Ventilator Dependent (Vent) Waiver

The Mechanical Ventilator Dependent waiver (Vent) waiver is designed to serve Medicaid-eligible participants aged 21 or older who are dependent on mechanical ventilation at least six (6) hours per day and have long term care needs. Participants can receive services to supplement care in their home to avoid or delay costly nursing home admission, through careful assessment, service planning and service coordination.

Medically Complex Children (MCC) Waiver

The Medically Complex Children (MCC) waiver is designed to serve children up to the age of twenty-one (21) diagnosed with a serious illness or condition expected to last at least twelve (12) months. The waiver participants must meet the following state-defined medical criteria, which identify the child as being dependent upon the evaluation of medications, hospitalizations, skilled nursing services, specialists, and ancillary services. The MCC waiver serves children who meet hospital level of care.

State Plan Services

Children's Personal Care (CPC) Services

CPC services provide personal care services in the community to Medicaid-eligible children under the age of twenty-one (21) years of age who meet established medical necessity criteria of at least one functional deficit.

Private Duty Nursing Services

Private Duty Nursing is available for children under twenty-one (21) years of age who meet established medical necessity criteria as outlined in the Children’s Private Duty Nursing Checklist.

Externally Operated Waivers

SCDDSN Operated Waivers

Head and Spinal Cord Injury (HASCI) Waiver

The HASCI waiver provides a broad range of HCBS to Medicaid-eligible participants with the most severe physical impairments involving head and spinal cord injuries, regardless of age. The HASCI waiver is designed to help participants who would otherwise require services in a nursing facility or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) to remain independent in the community.

Intellectual Disability/Related Disabilities (ID/RD) Waiver

ID/RD waiver services are provided based on identified needs of the participant and the appropriateness of the service to meet the need regardless of age. Participants must meet ICF/IID level of care criteria to

qualify for the waiver. A list of enrolled and qualified providers of ID/RD waiver services can be located at the SCDDSN website (www.ddsn.sc.gov) or by contacting the participant's Waiver Case Management provider

Community Supports (CS) Waiver

The CS waiver allows participants with an ID/RD to choose to receive care at home rather than in an ICF/IID. Although the participants may choose to receive care at home, he/she must require the level of care that would be provided in an ICF/IID. The CS waiver has an individual cost limit within which services are provided.

SCDHHS Money Follows the Person Demonstration Grant (Home Again)

Home Again serves Medicaid participants who have resided in a Medicaid-funded skilled nursing facility or hospital for sixty (60) days or more that wish to transition to a community setting. Home Again funds the first year of services before transitioning participants into one of the qualifying HCBS waivers in SCDHHS (Community Choices and HASCI). Participants must meet the Nursing Facility (NF) level of care...

Program of All-Inclusive Care for the Elderly (PACE)

South Carolinians who have either Medicare or Medicaid, or both, may join PACE. PACE covers all Medicare- and Medicaid-covered care and services, and other services that the PACE team of health care professionals decides are necessary to improve and maintain health. PACE is only available in certain counties in South Carolina. To qualify for PACE, you must:

- Be aged fifty-five (55) or older;
- Meet nursing home level of care;
- Wish to remain in the community; and,
- Choose to participate in the program.

Participants in PACE receive all services through PACE either directly from PACE staff, health care professionals or through subcontracted health care entities. Many of the services provided are centered in the PACE Adult Day Health Centers. Information regarding this program is available on www.scdhhs.gov.

Core Waiver Activities

Case Management

Case management, a vital part of the HCBS program, is provided for all waiver participants.

All waiver case management (WCM) activities for HASCI, CS and ID/RD waiver participants are provided by SCDDSN qualified providers and in accordance with SCDDSN policies and procedures.

Case management ensures continued access to HCBS programs. Case managers advise, support and assist participants and their families in coping with changing needs and in making decisions regarding long-term care.

WCM for CC, HIV, and Vent waivers includes the following activities: service counseling, service planning, service coordination, monitoring, quarterly face-to-face visits, and annual re-evaluation.

Pursuant 42 CFR 441.301(c)(1)(vi), SCDHHS contracted case management providers, and their staff must be independent of the delivery of other services on the participant's plan of care ("conflict-free case management"). These services include but are not limited to SCDHHS/SCDDSN waiver services, home health services, and hospice services. SCDHHS is the final decision authority regarding questions concerning conflict-free case management.

SCDDSN WCM provider directives, standards, and manuals can be located at https://ddsn.sc.gov/providers/ddsn-directives-standards-and-manuals.

Intake

The intake process identifies participants who may be eligible for the program and serves as an information and referral source for those who do not meet intake criteria. The SCDHHS CLTC Area Office and SCDDSN ensure that all participants with perceived long term care needs receive every opportunity for exposure to the waiver, identified state plan services and grant-funded programs. For MCC and PCSC, intake is completed by SCDHHS. Intake points of contact are as follows:

For all DHHS waiver applicant referrals, complete referral form at https://phoenix.scdhhs.gov/cltc_referrals/new.

For all SCDDSN waiver applicant referrals, call 1-800-289-7012.

Assessment

The Level of Care (LOC) uses a comprehensive standard instrument to determine an applicant's current long-term care needs. Information obtained during the assessment process will assist staff in making a level of care decision to determine eligibility for the waiver program as well as initiating a plan of service for discussion with the applicant and/or family. If the applicant is deemed eligible for the program. After enrollment in a waiver program, the participant is then re-evaluated annually to determine their continued eligibility for the waiver program.

Service Planning

Once a participant is enrolled in a waiver program, the service planning process will take place. Service planning encompasses a comprehensive review of the participant's problems and strengths utilizing a person-centered approach. Mutually agreed-upon goals are set based on identified needs. This service planning process allows for participation of the participant and/or family, physician, service providers, and/or the case management team. Service planning provides participants with information necessary to make an informed choice regarding the location of care and services to be utilized. The outcome of this process is a written plan of service. The Service Planning process is conducted annually and must be completed at least every 365 days.

For further clarification regarding policies and standards for SCDDSN operated waivers, please see https://ddsn.sc.gov/

NOTE: References to supporting documents and information are included throughout the manual. This information is found at the following locations:

- Provider Administrative and Billing Manual

- Fee Schedule
- Procedure Codes Forms

2
COVERED POPULATIONS

ELIGIBILITY/SPECIAL POPULATIONS
Beneficiary Requirements

The South Carolina Department of Health and Human Services (SCDHHS) Home and Community- Based Services provides reimbursement for medically necessary services for full-benefit Medicaid- eligible participants who are determined to meet the level of care and have been enrolled in the waiver programs as specified in the list below:

Program	Medical Eligibility Assessment Tool	NF Level of Care	ICF-IID Level of Care	Child & Adolescent Service Intensity Instrument	Hospital
CC		Skilled or Intermediate			
Vent		Skilled or Intermediate			
HIV/AIDS					Hospital
MCC	8 or above				Hospital
PCSC				Meet criteria in one dimension	Hospital
HASCI		Skilled or Intermediate	Meets		
ID/RD			Meets		
CS			Meets		
Home Again		Skilled or Intermediate			

MCC Waiver requires the participant to meet the requirements of both being at risk for hospitalization and the criteria for the Medical Eligibility Assessment Tool. Assessment reviews the following criteria:

- Medications in the child's plan of treatment are necessary throughout the day: This criterion is to be applied to the individual's need for medication administration and includes the frequency

and clinical skill involved. The criteria specify the route of administration, frequency required and assessment for effectiveness.

- Within the last 12 months there has been a significant medical condition that requires hands-on medical supervision and monitoring by a trained professional due to the high probability for health complications, or adverse reactions due to the complexity of the child's condition.
- The child's condition requires complex and comprehensive hands-on nursing care.
- There are significant and complex medical conditions that require comprehensive medical supervision and coordination of multiple medical providers (i.e., specialty care physicians) due to multiple diagnoses, complexity of health conditions and high probability for health complications, due to the complexity and intensity of the child's conditions.
- The child's daily routine is substantially altered by the need to complete specialized and time-consuming treatments or the need for two or more types of prescribed therapeutic therapies provided by a licensed professional. This refers to medically appropriate and medically focused, such as PT, OT, and Speech Therapies. It does not include recreational or psychological therapies.

For PCSC, the CASII has six dimensions that are used to determine the intensity of the services needed which are:

- Risk of Harm
- Functional Status
- Co-Morbidity
- Recovery Environment
- Resilience and Treatment History
- Acceptance and Engagement

Verifying Beneficiary's Eligibility

Healthy Connections providers must verify eligibility information through the SCDHHS Medicaid Web Portal Customer Service Center. Beneficiaries must be eligible on the date of service for payment to be made.

3

ELIGIBLE PROVIDERS

PROVIDER QUALIFICATIONS

All HCBS services have prerequisites for participation and require enrollment/contracts with SCDHHS. Certain licensing requirements may also exist. Please see the Provider Administrative and Billing Manual for general Medicaid enrollment and licensing requirements.

For general information regarding provider qualifications and enrollment in the South Carolina Healthy Connections Medicaid program please refer to the Provider Administrative and Billing Manual. Specific provider qualifications for HCBS vary depending on the service. Qualifications for each provider can be found in HCBS Scopes and Standards linked below.

- ADHC Nursing
- Adult Day Health Care
- Advanced Pest Control Standards
- Attendant Care (Self-Directed)
- Case Management
- Children's Attendant Care (Self-Directed)
- Children's Persional Care (State Plan)
- Companion (Agency)
- Companion (Self-Directed)
- Environmental Modifications Standards
- Home Delivered Meals
- Institutional Respite
- Nursing Services
- Pediatric Medical Day Care
- Personal Care, HASCI Attendant Care, ID/RD Respite, CS Respite, and MCC Unskilled Respite
- Personal Emergency Response System (PERS)
- Pest Control Standards
- Residential Personal Care
- Respite CRCF
- Skilled In-Home Respite Vent
- Skilled Respite MCC
- Telemonitoring
- Transition Coordination

HCBS providers must meet all applicable Medicaid provider qualifications and state licensure regulations specified by the South Carolina Department of Labor, Licensing and Regulation (LLR) and

the Department of Public Health (DPH). Medicaid reimbursement is available for Home and Community-Based Services when provided by the qualified Home and Community-Based Services provider per the prior authorization process.

Providers who are already enrolled to provide a HCBS service can email provider-distribution@scdhhs.gov, or contact Provider Enrollment staff at 1-888-289-0709 ext. 4 for more information regarding how to add additional services. For providers already enrolled as Personal Care Providers who want to add Nursing Services, they must demonstrate that they are compliant with current Personal Care Scope requirements by having a score of less than 100 on their last compliance reviews.

Services rendered by the HCBS provider must conform to the federal and state laws, rules, and regulations.

The providers whose scopes are listed above are eligible to enroll with SCDHHS to bill HCBS delivered to eligible participants. Providers for Adult Day Health Care, Adult Day Health Care Nursing, Nursing Services, Personal Care Services, Pest Control, Personal Emergency Response System, and Respite Care Providers can also provide HCBS to eligible members in a SCDDSN-operated waiver.

For specific requirements on Provider enrollment refer to SCDHHS's website at: https://www.scdhhs.gov/providers/become-provider

SCDDSN operated waivers have extended state plan services that are provided by state plan enrolled providers: Adult Vision, Adult Dental, Audiology, Specialized Medical Equipment and Assistive Technology, Specialized Medical Equipment and Assistive Technology Consultation, Incontinence Supplies, Occupational Therapy, Physical Therapy, and Psychological Services. Provider requirements for these services can be found on the www.scdhhs.gov website.

Note: Adult Vision services provider requirements are found in the Physician Services manual, and Psychological Services provider requirements are found in the Rehabilitative Behavioral Health Services provider manual.

Please refer to the SCDDSN website at https://ddsn.sc.gov/ for more information for services that require SCDDSN qualification. Please note that Companion Services for SCDHHS does not allow providers to provide services for SCDDSN participants. Adult Companion Service providers must be qualified through SCDDSN.

Enrolled providers are prohibited from using their NPI to bill Medicaid for services rendered by a non-enrolled, terminated or excluded provider.

HCBS Settings Requirements (Applicable for Adult Day Health Care, Day Services, Pediatric Medical Day Care, and Residential Habilitation)

The HCBS Settings regulation, effective March 2024, sets forth where and how Medicaid home and community based services (HCBS) are provided and ensures that people receiving services and supports through Medicaid's HCBS programs have full access to the benefits of community living and are able to receive services in the most integrated setting.

The HCBS regulation requirements apply to each of SCDHHS's 1915(c) waivers.

Pursuant to 42 CFR 441.301 (c)(4), all HCBS settings must have the following qualities:

- The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.
- The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences and, for residential settings, resources available for room and board.
- Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.
- Optimizes, but does not regiment, individual initiative, autonomy and independence in making life choices, including but not limited to, daily activities, physical environment and with whom to interact.
- Facilitates individual choice regarding services and supports, and who provides them.

For provider owned and/or controlled residential HCBS settings, CMS has listed the following additional conditions that must be met (per 42 CFR 441.301(c)(4)(vi)):

- A legally enforceable agreement (lease, residency agreement or other form of written agreement) is in place for each individual in the HCBS home/setting within which he/she resides.
- Each individual has privacy in their sleeping or living unit.
- Units have lockable entrance doors with the individual and appropriate staff having keys to doors as needed.
- Individuals sharing units have a choice of roommates.
- Individuals can furnish and decorate their sleeping or living units within the lease or other agreement.
- Individuals have freedom and support to control their schedules and activities.
- Individuals have access to appropriate food any time.
- Individuals may have visitors at any time.
- The setting is physically accessible to the individual.
- Any modification of the additional conditions for HCBS residential settings listed above must be supported by a specific assessed need and justified in the person-centered service plan.

CMS has also listed the following as settings that are not home and community-based (per 42 CFR 441.301 (c)(5)):

- A nursing facility.
- An institution for mental diseases (IMD).
- An intermediate care facility for individuals with intellectual disabilities (ICF/IID).
- A hospital.

- Any other settings that have the qualities of an institutional setting. This includes:
- Any setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment.
- Any setting in a building on the grounds of, or immediately adjacent to, a public institution.
- Any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS.

Note: Any of the settings that have qualities of an institutional setting will be presumed to be institutional, and therefore HCBS cannot be provided in that setting unless assessed by SCDHHS and/or its designee(s) to determine compliance with the regulation. SCDHHS and/or its designee(s) determines through heightened scrutiny whether the setting has the qualities of home and community-based settings and services can still be provided in that setting.

Institutional Presumption

Settings presumed to be institutional but where services are truly individualized, person-centered and integrated into the broader community can be determined compliant only by SCDHHS and/or its designee(s). No HCBS provider should assume a setting presumed to be institutional is determined to be compliant without written confirmation from SCDHHS or its designee(s). All Providers who believe a setting presumed to be institutional is compliant must contact MedicaidWaiver@scdhhs.gov about the setting to receive confirmation.

Providers who provide HCBS in ADHCs, Day Services programs, and Residential Habilitation programs that meet Category 1, Category 2 and Category 3, as defined below, must be assessed by SCDHHS and/or its designee(s) to determine compliance with the regulation. The agency will require that the settings in which Medicaid HCBS waiver services may be delivered demonstrate, before receiving Medicaid reimbursement for HCBS waiver services, that the setting is free from program design, operation characteristics, and programmatic practices that have the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS.

Category 1: Any setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment

Category 2: Any setting in a building on the grounds of, or immediately adjacent to, a public institution, with public institution defined as an inpatient facility that is financed and operated by a county, state, municipality, or other unit of government

Category 3: Any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS

Settings may, if compliance is demonstrated, be certified by the state as HCBS waiver compliant and be allowed to seek Medicaid reimbursement for services rendered. Some examples include, but are not limited to:

- A Community Residential Care Facility (CRCF) that was formerly an ICF/IID, and is physically located next to another CRCF that was also formerly an ICF/IID
- A disability specific complex such as HUD 811 apartment complex
- A setting with a locked fence around the property
- Three (3) or more HCBS settings clustered together operated by the same provider

Ongoing Compliance

It is through SCDHHS's established systems of quality assurance and compliance review that ongoing compliance of HCBS standards will be monitored.

New providers and new settings will be reviewed on a site visit to ensure 100% compliance with these requirements prior to enrollment. After the initial enrollment, compliance monitoring will ensure continued compliance with these requirements. Any non-compliance with these requirements will result in remediation and possible sanctions up to termination of the provider with SCDHHS for non-compliance. Providers deemed compliant must maintain compliance with the HCBS Settings regulation in order to receive reimbursement for HCBS waiver services.

There are established compliance systems in place at SCDHHS and SCDDSN that monitor providers and their services to ensure they are compliant in providing the waiver services as stated in their contracts/enrollment agreements which are congruent with the approved waiver applications. For the SCDDSN operated waivers, SCDHHS will conduct ongoing monitoring to include compliance site visits in addition to the monitoring completed by SCDDSN and the Quality Improvement Organization (QIO).

HCBS settings reviews will be incorporated into onsite visits and settings found not to be in compliance will be subject to remediation and possible sanctions up to termination of the provider or the setting with SCDHHS for non-compliance.

HCBS Settings

CMS released a set of Exploratory Questions to assist states in their assessment of residential and non-residential HCBS settings This tool was provided to assist states in assessing whether the characteristics of Medicaid HCBS as required by regulation, are present. The information is organized to cite anticipated characteristics and to provide suggested questions to determine if indicators of that characteristic are present. Providers and potential providers are encouraged to utilize this tool to conduct self-assessment in regards to compliance with the federal settings requirements.

CMS Exploratory Questions

4

QUALITY ASSURANCE

OVERVIEW OF SCDHHS COMPLIANCE REVIEW PROCESS

SCDHHS and SCDDSN have implemented Quality Assurance processes to ensure that providers are following the requirements as outlined in policy and scopes of services.

Note: SCDDSN has a separate Quality Management process. Information regarding their Quality Assurance Process can be found here: https://ddsn.sc.gov/ddsn-divisions/quality-management

For Adult Day Health Care (ADHC), Personal Care Services (PCS), and Nursing Services (NS) only, SCDHHS has developed this provider compliance policy. The policy gives detailed information on how provider compliance sanctions are implemented. Provider reviews receive a score based on a sanctioning scale; review scores will determine if the provider receives a sanction and if so, the level of the sanction. The sanction scoring process was developed to ensure that reviews are equitable and for providers to know what to expect when they are reviewed.

The following chart outlines how reviews are scored:

Sanction Level

Provider compliance review questions in the Scope of Services are classified into three severity levels, based on (1) the significance of the question regarding the services, and (2) the potential influences on providers and participants if the requirement was not met. See the example below:

Severity level: 1= less serious, 2 = serious, 3 = very serious

Participant Service Questions	Possible Answers	Severity Level
Was supervisory visit made within 30 days after PC services initiated?	Y, N, NA	3
Was the initial supervisory visit documented in the Electronic Visit Verification (EVV) System?	Y, N, NA	3
Does provider maintain individual participant records?	Y, N	2
Did provider give participant written information regarding advanced directives?	Y, N, NA	1

Sanctions:

- **Corrective Action Plan (CAP)** - This is the lowest sanction and indicates the provider is in substantial non-compliance with the contractual requirements. Providers with an initial compliance score of 50 or more will be required to submit a plan of correction outlining the deficiency(ies), the detailed plan to correct the deficiency(ies) and the effective date the plan will be implemented. A CAP Template is in Phoenix Help Documents under Miscellaneous Forms that providers may choose to use. If the corrective action plan is not approved, the Provider will be given an additional ten (10) business days to submit another corrective action plan for review and approval. If the second submitted corrective action plan is not approved, the provider will be suspended from providing new referrals until the corrective action plan has been received and approved. Please note, any documentation that was not available during the compliance visit will not be accepted as a part of the plan of correction. All documentation must be in the appropriate record at the time of the review.
- **Educational Intervention-** At this level, the provider is requested to have the appropriate staff attend training by the South Carolina Department of Health and Human Services to improve knowledge of HCBS policies and procedures/Scope of Services. Educational Intervention is **required** if the compliance score is 100 or more points. If Educational Intervention training has not been received within 30 days of sanction, the provider will be suspended from receiving new referrals until the educational training is received.

  Providers may request educational training provided by SCDHHS at any time by sending an email request to: provider-distribution@scdhhs.gov
- **90-day suspension –** Indicates an initial (interim) review with four hundred (400) or more points indicating serious and widespread deficiencies, new referrals are suspended for ninety (90) days.
- **Termination –** Indicates a routine review final review score of four hundred (400) or more points or very serious and widespread deficiencies. Providers who have been terminated due to a compliance review cannot reapply to be a provider of SCDHHS/SCDDSN services for three (3) years from the date of termination.

  Providers who have two (2) consecutive reviews with a score of 100 or more, will be terminated if the third consecutive review has a final score of 100 and above.

Calculating process

SCDHHS has developed a system to score reviews based on the percentage of the identified deficiency and number of participants surveyed. The following is an outline of how reviews will be scored:

The level of sanction will be decided based on the total score of the provider's current review and the provider's review history, which is converted from the deficiency percentage.

Every 5% deficiency counts for 1 point in each class; the total score comes from the total points from each level.

Since each level has different severity, multiple points will be added to each class's score. Final score = level

3 = unweighted points x 3 + level 2 = unweighted basic points x 2+ level 1 = unweighted points x 1

Example:

Level	Deficiency percentage	Basic points	Final points
Level 1 (less serious)	28%	5	5x1=5
Level 2 (serious)	20%	4	4x2=8
Level 3 (major)	35%	7	7x3=21
Final score			34

Based on the total score a sanction level is determined. If a provider has no deficiencies, they will not be subject to a sanction. Below is a chart that illustrates the sanction that will be imposed based on the final review score:

Score	w/ Good History*	Sanction
0-50	0-99	No further sanction
51-99	100-149	Corrective Action Plan
100-399	150-449	Mandatory educational training
Initial Review 400 or above	n/a	90-day suspension of new referrals and mandatory educational training
Routine Review 400 or above	Routine Review 450 or above	Termination

*Good History is determined based on previous review scores of 50 or below. For example, if a provider's previous review had a total score of **50** and their current review has a score of **120**, the sanction for the current review will be corrective action rather than mandatory educational training based on the previous review score.

Scores are automatically calculated using a computer-generated compliance review program.

Provider records will be reviewed periodically at the provider's office or obtained from the provider's office for later review. Onsite visits are unannounced. If a reviewer (HCBS, Program Integrity or any other government entity) arrives at the provider's office to conduct a survey/visit and/or obtain records for a survey and no one is there, the following sanctions will be imposed:

- First time – thirty (30) day suspension of new referrals
- Second time – ninety (90) day suspension of new referrals

- Third time – contract termination

Note ADHC Providers Only:

Center for Medicare and Medicaid Services (CMS) requires Adult Day Health Care Centers servicing HCBS (waiver) participants to be in compliance with the HCBS settings requirements.

Providers of Adult Day Health Care Services must meet all requirements as outlined in 42 CFR § 441.301(c)(4)). These requirements have been integrated into the HCBS Adult Day Health Care Provider Scope of Services.

SCDHHS will terminate contracts with **existing** ADHC providers whose settings do not meet all the requirements outlined by CMS for the HCBS settings regulation.

New providers are trained on all ADHC HCBS Setting requirements and settings are reviewed in a site visit to ensure that the ADHC is 100% compliant with these requirements prior to enrollment to provide services. After the initial enrollment, compliance surveys will ensure continued compliance with these requirements. Any non-compliance with these requirements the compliance survey process will result in remediation and possible sanctions up to termination of your contract with SCDHHS for the non-compliant setting.

5

COVERED SERVICES AND DEFINITIONS

A table displaying the related program that covered services are associated with is included here with their definitions to follow.

	State Plan	Community Choices Waiver	CS Waiver	HASCI Waiver	HIV/AIDS Waiver	Home Again	ID/RD Waiver	Mechanical Ventilator Dependent Program	MCC Waiver	PCSC Waiver
Adult Companion Services							X			
Adult Day Health Care (ADHC) Nursing		X	X			X	X			
ADHC Services		X	X			X	X			
Adult Dental							X			
Adult Vision							X			
Advanced Pest Control		X				X				
Assistive Technology and Appliances			X							
Assistive Technology and Appliances Assessment/ Consultation			X							
Attendant Care Services		X		X	X	X	X	X		
Audiology Services				X			X			
Behavior Support Services			X	X			X			
Career Preparation Services			X	X			X			
Case Management		X			X	X				
Children's Attendant Care									X	
Children's Personal Care	X									
Community Services (Individual and/or Group)			X				X			
Companion Services		X			X	X				
Day Activity			X	X			X			

	State Plan	Community Choices Waiver	CS Waiver	HASCI Waiver	HIV/AIDS Waiver	Home Again	ID/RD Waiver	Mechanical Ventilator Dependent Program	MCC Waiver	PCSC Waiver
Employment Services			X	X			X			
Environmental Modifications		X	X	X	X	X	X	X	X	
Environmental Modification, Specialized Supplies, and Adaptations		X			X	X		X		
Expanded Goods and Services						X				
Habilitation Services (Day)					X					
Habilitation Services (Prevocational)										
Habilitation Services (Residential)				X			X			
High Fidelity Wrap Around										X
Health Education for Consumer-Directed Care				X						
Home Delivered Meals		X			X	X		X		
In-Home Supports			X							
Incontinence Supplies	X									
Individual Directed Goods and Supplies (IDGS)										X
Nursing Services	X (up to 21)			X	X		X	X		
Nurse Care Coordination									X	
Occupational Therapy				X						
Pediatric Medical Day Care									X	
Peer Guidance for Consumer-Directed Care				X						
Personal Care Services (PCS)		X	X		X	X	X	X		
Personal Emergency Response System (PERS)		X	X	X		X	X			
Pest Control		X			X	X		X		
Pest Control – Bed Bugs				X			X			
Physical Therapy				X						
Private Vehicle Modification			X	X			X			
Private Vehicle Modification Assessment/Consultation										

	State Plan	Community Choices Waiver	CS Waiver	HASCI Waiver	HIV/AIDS Waiver	Home Again	ID/RD Waiver	Mechanical Ventilator Dependent Program	MCC Waiver	PCSC Waiver
Psychological Services				X						
Respite (In-Home)			X				X	X	X	
Respite (Institutional/NF)		X	X	X			X	X		
Respite Care in a Community Residential Care Facility		X								
Specialized Medical Supplies, Equipment and Assistive Technology							X			
Specialized Medical Supplies, Equipment and Assistive Technology Assessment/Consultation					X		X			
Skilled Respite Services										
Speech and Hearing Services				X						
Support Center Services			X				X			
Transition Coordination						X				
Tele-Monitoring		X				X				
Waiver Case Management			X	X			X			
Unskilled Respite										X

Adult Companion Services

Non-medical care, supervision and socialization, provided to a functionally impaired adult individual. Companions may assist or supervise the individual with such tasks as meal preparation, laundry and shopping, but do not perform these activities as discrete services. The provision of companion services does not entail hands-on nursing care but may entail hands-on assistance or training to the recipient in performing activities of daily living and independent living skills. Providers may also perform light housekeeping tasks which are incidental to the care and supervision of the individual. This service is provided in accordance with a therapeutic goal in the plan of care and is not diversional in nature. Reimbursement will not be made to any family members residing in the same residence as the individual.

Up to 28 hours per week based on SCDDSN assessed need. When Adult Attendant Care is authorized in conjunction with Adult Companion and/or Personal Care, the combined total hours per week of services may not exceed 34. The unit of service is one hour provided by one Attendant Care Aide. However, the limits may be exceeded if applying the limits would create a substantial risk that the individual would no longer be able to live in the community, but would, because of the limit in services, have to be institutionalized. Cost of incidental transportation is included in the rate paid to the provider.

Adult Day Health Care Services

Services generally furnished five or more hours per day 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 regimen" (3 meals per day).

Adult Day Health Care-Nursing Services

Licensed nursing services provided on a part-time or intermittent basis while the participant is attending ADHC. Nursing procedures are limited to ostomy care, urinary catheter care, decubitus and/or wound care, tracheostomy care, tube feedings, and nebulizer treatments which require medication. This service must be ordered by a physician to meet the participant's care needs.

Adult Dental Services

The service is defined and described in the approved State Plan and will not duplicate any service available to adults aged 21 and older in the State Plan. Items/services allowed under the waiver are the same as the standard items/services for children under age 21 covered under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)services mandate; items/services requiring a prior authorization are not allowed.

Services that are provided when the limits of dental services under the approved state plan are exhausted. The scope and nature of these services do not otherwise differ from dental services furnished under the state plan. The provider qualifications specified in the state plan apply. The additional services that may be provided through the waiver are as follows: Services are for those 21 and over.

Adult Vision Services

Services that are provided when the limits of adult vision under the approved state plan are exhausted. The scope and nature of these services do not otherwise differ from adult vision services furnished under the state plan. The provider qualifications specified in the state plan apply. The additional amount of services that may be provided through the waiver is as follows: Services are for those 21 and over.

Advanced Pest Control

Advanced Pest Control services aid in maintaining an environment free of bed bugs to promote safety, sanitation, and cleanliness of the participant's residence. Once the existence of bedbugs is established as existent within the home, providers treat the residence to eliminate infestation. The provider must return to the home and provide re-treatment as necessary within a one-year warranty time frame from the authorization of initial treatment.

Assistive Technology and Appliances

Assistive Technology and Appliances is a device, an item, piece of equipment, or product system that is used to increase or improve functional capabilities of participants, thereby resulting in a decrease or avoidance of need for other waiver services. Service may include training or technical assistance for the participant, or, where appropriate, the family members, guardians, advocates, or authorized representatives of the participant. Appliances intended for general household utility that do not result in a decrease in need for other waiver services are not covered. This service is not intended to replace traditional household appliances for the convenience of family/household members or caregivers. Additionally, devices, items, equipment and/or product systems not proven effective, or deemed trial or experimental are not covered. Repairs not covered by warranty are covered, and replacement of parts/equipment are covered, if these repairs or parts/equipment are not related to abuse, mistreatment or carelessness. The lifetime limit on repairs (not covered under warranty) and/or replacement of parts/equipment is $1,000. To the extent that any listed services are covered under the state plan, the services under the waiver would be limited to additional services not otherwise covered under the state plan, but consistent with waiver objectives of avoiding institutionalization.

Assistive Technology and Appliances Assessment/Consultation

Assistive Technology and Appliances Assessment/Consultation may be provided (if not covered under the State Plan Medicaid) once a participant's specific need has been identified and documented in the Support Plan. The scope of the work and specifications must be determined. Consultation and assessment may include specific needs related to the participant's disability for which assistive technology and/or appliances will assist the participant to function more independently. Appliances intended for general household utility that do not result in a decrease in need for other waiver services are not covered. This service is not intended to replace traditional household appliances for the convenience of family/household members or caregivers. Additionally, devices, items, equipment and/or product systems not proven effective, or deemed trial or experimental are not covered.

Assistive technology and assessments/consultations must be provided by Medicaid enrolled Occupational or Physical Therapists, Medicaid enrolled Rehabilitation Engineering Technologists, Assistive Technology Practitioners and Assistive Technology Suppliers certified by the Rehabilitation Engineering Society of North American (RESNA), Medicaid enrolled Environmental Access/Consultants/contractors certified by Professional Resource in Management (PRIME).

Attendant Care Services

Self-directed hands-on care of both a supportive and health-related nature. Supportive services are those which substitute for the absence, loss, diminution, or impairment of a physical or cognitive function. This service may include skilled or nursing care to the extent permitted by state law. Limited housekeeping activities, which are incidental to the performance of care, may also be furnished as part of this activity.

Audiology Services

Audiology Services are an extension to the audiology services included in the State Plan. In the State Plan, specified audiology services are only available to Medicaid beneficiaries who are under age 21. The waiver service removes the age restriction, making the same audiology services available to those who are over age 21. This service will not duplicate any services available to adults in the State Plan.

Behavior Support Services

Behavior Support are those services which use current, empirically validated practices to identify functions of target behaviors, prevent the occurrence of problem behavior, teach appropriate, functionally equivalent replacement behavior and react therapeutically to problematic behavior. These services include:

a. Initial behavioral assessment for determining the need for and appropriateness of behavior support services and for determining the function of the behaviors. Behavioral assessment (i.e., functional assessment and/or analysis) includes direct observation and collection of antecedent-behavior-consequence data, an interview of key persons, a preference assessment, collection of objective data (including antecedent-behavior-consequence data) and analysis of behavioral/functional assessment data to determine the function of the behaviors;

b. Behavioral intervention (including staff/caregiver training), based on the functional assessment, that is primarily focused on replacement and prevention of the problem behavior(s) based on their function; and

c. An assessment of the success of the intervention through progress monitoring that includes analysis of behavioral data, any changes (including medication) and any needed modifications.

d. Caregiver Coaching services: To provide a support system to unpaid caregivers who are caring for family members with challenging behaviors, caregiver coaching services may be provided. The purpose of caregiver coaching is to enable the health, safety, well-being and continued community integration of waiver participants by equipping family caregivers with the skills and resources necessary to manage the participants' behavioral and associated needs at home. This service is not provided directly to waiver participants, but to their family caregiver(s). A participant has to be assessed by a waiver case manager to need the behavior support service before the family caregiver can access caregiver coaching. The waiver participant does not have to be actively receiving behavioral services in order for the family caregivers to receive caregiver coaching.

Career Preparation Services

Career preparation services are time-limited and aimed at preparing individuals for competitive employment and engaging a participant in identifying a career direction. These services can include experiences and exposure to careers and teach such concepts as attendance, task completion, problem-solving, interpersonal relations and safety as outlined

in the individual's person-centered plan. Services are designed to create a path to integrated community-based employment for which an individual is compensated at or above minimum wage. On-site attendance at the licensed facility is not required to receive services that originate from the facility. The cost for transportation is included in the rate paid to the provider.

Transportation will be provided from the individual's residence to the habilitation site when the service start time is before 12 p.m. Transportation will be available from the individual's habilitation site to their residence when the service start time is after 12 p.m.

Case Management (SCDHHS)

Services that assist participants in gaining access to needed waiver and other state plan services, as well as medical, social, educational, and other services regardless of the funding source for the services accessed. Case managers are responsible for ongoing monitoring and the coordination of the provision of services included in the participant's person-centered service plan.

At a minimum, case management activities include initial visit, monthly contact, quarterly visit and re-evaluation visit. At least one of these case management activities must be completed every month and documented appropriately.

Case management providers are not permitted to provide other direct waiver services or other services that are part of a participant's person-centered service plan. Case managers are not allowed to receive any gifts or anything else of value from providers of waiver services. During case management orientation training, case managers are informed of conflict-of-interest requirements and must sign a disclosure form indicating understanding and agreement.

Children's Attendant Care (CAC) Services

CAC services provide extraordinary hands-on care in the home to children enrolled in the Medically Complex Children waiver who require help with at least two of the seven activities of daily living. Extraordinary care is defined as support that exceeds the range of tasks a family member or responsible person would normally perform in the household for a person without a disability or chronic illness of the same age. The activities of daily living include bathing, dressing, eating, hygiene, mobility, toileting, and transferring.
CAC is a self-directed service model and can be used instead of an in-home care agency and personal care aide (PCA). It allows for eligible parents, relatives or guardians to be paid hourly to deliver the extraordinary care their child needs for day-to-day activities.

Children Personal Care (CPC)

Children's Personal Care services are available to all recipients under age 21 who live at home and who are found to be in need of such services on the basis of state established medical necessity criteria. CPC Services are designed to enable participants to accomplish tasks that they would normally do for themselves if they did not have a disability. This assistance may take the form of hands-on assistance (performing a task for the person) or cueing to prompt the participant to perform a task. Such assistance may include assistance in

activities of daily living (bathing, dressing, toileting, transferring, maintaining continence, etc.). Instrumental Activities of Daily Living (IADL's) for members aged 16 and above including home support (cleaning, laundry, shopping, home safety and errands) may be done as a part of the assistance given in the provision of activities of daily living. Personal care services may be provided on an episodic or on a continuing basis and are performed by personal care agencies.

Community Services

Community services are aimed at developing one's awareness of interaction with and/or participation in their community through exposure to and experience in the community and through teaching such concepts as self- determination, self-advocacy, socialization and the accrual of social capital. Services will be provided in facilities licensed by the state. On-site attendance at the licensed facility is not required to receive services that originated from the facility.

Transportation will be provided from the individual's residence to the habilitation site when the service start time is before 12 p.m. Transportation will be available from the individual's habilitation site to their residence when the service start time is after 12 p.m. The cost for transportation is included in the rate paid to the provider.

Companion (Agency or Self-Directed)

Non-medical care, supervision, and socialization provided to a functionally impaired adult. Companions may assist or supervise the participant with light housekeeping tasks. Providers may also perform light housekeeping tasks that are incidental to the care and supervision of the participant. The provision of companion services does not entail hands-on care or assistance with activities of daily living; the companion care service does not duplicate the provision of the personal care service. This service is provided in accordance with a therapeutic goal in the service plan. There is a self-directed option for companion services.

Day Activity

Supports and services provided in therapeutic settings enable participants to achieve, maintain, improve, or decelerate the loss of personal care, social or adaptive skills. Services are provided in non-residential settings that are licensed by the state. Community activities that originate from a facility licensed by the state will be provided and billed as day activity. On-site attendance at the licensed facility is not required to receive services that originate from the facility.

Transportation will be provided from the participant's residence to the habilitation site when the service start time is before 12 p.m. Transportation will be available from the participant's habilitation site to their residence when the service start time is after 12 p.m. The cost for transportation is included in the rate paid to the provider.

Employment Services (Individual)

Employment services (Individual) are the ongoing supports to individuals who, because of their disabilities, need intensive ongoing support to obtain and maintain an individual job in

competitive or customized employment, or self-employment, in an integrated work setting in the general workforce for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. Transportation is not included as part of the service, or the rate paid for individual job placement.

Employment Services (Group)

Employment services - group is the ongoing supports to individuals who, because of their disabilities, need intensive ongoing support to obtain and maintain an individual job in competitive or customized employment, or self-employment, in an integrated work setting in the general workforce for which an individual is compensated at or above minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. Employment services – group is provided in group settings, such as mobile work crews or enclaves and employees may be paid directly by the employer/business or by the employment services – group provider.

Employment services - group is not a prerequisite for employment services – individual.

Transportation will be provided from the individual's residence to the habilitation site when the service start time is before 12 p.m. Transportation will be available from the individual's habilitation site to their residence when the service start time is after 12 p.m.

Environmental Modifications (SCDHHS)

Those physical adaptations to the private residence of the participant or the participant's family, required by the participant's service plan, that are necessary to ensure the health, welfare, and safety of the participant or that enable the participant to function with greater independence in the home. Such adaptations include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, provision of air conditioning units, and installation of specialized electric and plumbing systems necessary to accommodate the medical equipment and supplies required for the welfare of participants.

These services may only be authorized based on a health and/or safety related issue. Case managers must evaluate the expressed need prior to authorizing the service. During this process, the case manager determines that there is an assessed need for the items, updates appropriate sections of Phoenix (the case management system used by case managers and staff) to indicate the need for the items, updates the participant's service plan, and requests prior approval in the service approval section of the service plan (including date the last item was received (if applicable).

Per policy, the service justification for air conditioning units must emphasize the need based on health and safety related issues with specific information provided associating requests with a medical condition. The provision of air conditioning units is not intended for general utility and shall not be executed as such. Regional Office staff review related requests and either approve or deny, utilizing medical expertise offered through Lead Team Nurses in Regional offices, and/or Medical Director in Central Office, as needed. Following approval the case manager may begin the authorization process.

This service is limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

There is a lifetime cap of $7,500 per participant.

Environmental Modifications (SCDDSN)

Those physical adaptations to the home, required by the individual's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence, and without which, the individual would require institutionalization. Home is defined as non-government subsidized living quarters, and modifications to any government-subsidized housing (i.e., group homes or community residential care facilities) are not permitted. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, and/or modification of bathroom facilities which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the individual. Environmental modifications may also include consultation and assessments to determine the specific needs and follow-up inspections upon completion of the project. Excluded are those adaptations or improvements to the home, which are of general utility, and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, awning additions, etc. The following adaptations are excluded from this waiver benefit: modifications that add square footage to the home, pools, decks, stairs, elevators, breezeways, carports and hot tubs/whirlpools. All modifications shall be provided in accordance with applicable State or local building codes. Home accessibility adaptations may not be furnished to adapt living arrangements that are owned or leased by providers of waiver services. Approval of a request for environmental modification is a multi-step process. The modification is initially determined by the waiver case manager/early interventionist based on the recipient's need as documented in the plan of care. According to State procurement policy, bids for the modification are obtained by the waiver case manager/early interventionist (WCM/EI) and submitted with documentation of the need. This information is reviewed by SCDDSN staff for programmatic integrity and cost effectiveness. The environmental modification service must be within the lifetime monetary cap of $15,000 per recipient. The WCM/EI will assist in identifying all appropriate resources, both waiver and non-waiver. Should it become necessary, the WCM/EI will assist with transitioning the client into institutional placement.

Expanded Goods and Services

Home Again provides expanded goods and services to assist participants in being prepared for the transition into the community. These services include furniture, appliances, groceries, security deposits, utility deposits, household items, and other non-covered items up to a cap of $6000 per participant.

Health Education for Participant-Directed Care

Health education for participant-directed care prepares capable individuals who desire to manage their own personal care or a family member or other responsible party who desires to manage the personal care of an individual not capable of self-management.

Health education for participant-directed care is instruction provided by a licensed registered nurse who is provided the “Key to Independence Manual” from the Shepherd Center in Atlanta, Georgia and/or other curricula approved by SCDDSN/SCDHHS in the provision of this service. The training provided by an RN will regard the nature of specific medical conditions, the promotion of good health, and the prevention/monitoring of secondary medical conditions.

High Fidelity Wraparound

High fidelity wraparound (HFW) is a team-based approach to caring for families with complicated needs. The function of performing wraparound facilitation is to identify who should be involved in producing a community-based, person-centered plan to meet the needs of the participant. Those identified family, extended family and other community members comprise the participant and family team and play a vital role in the development of the person-centered plan.

The wraparound facilitator guides the person-centered plan development process, assures that waiver rules are followed and is responsible for reassembling the team when subsequent person-centered plan review and revision are needed. Reassembling happens with warranted changes in the participants’ circumstances. The wraparound facilitator emphasizes building collaboration and coordination among family-identified caretakers, service providers and other formal and informal community resources. The participant and family team meet with the wraparound facilitator to perform the four functions of home and community-based services (HCBS) care management: assessment, person-centered planning, referral to services and monitoring of health and welfare and service delivery. Wraparound coordination with other child serving systems should occur as needed. All coordination must be documented in the participant’s medical record. The high-fidelity entity must ensure that all participant and family team members adhere to the HCBS requirements found at 42 CFR 441.301(c).

Participant and family teams receive regular clinical supervision by a Licensed Practitioner of the Healing Arts employed by the HFW entity. Wraparound coaches and trainers credentialed by the National Wraparound Implementation Center (NWIC) must be members of HFW teams. Further, HFW teams must demonstrate continued use of evidence-based wraparound standards as approved by SCDHHS through ongoing participation in wraparound fidelity monitoring.

SCDHHS contracts solely with the COC to perform the HFW service. The COC implemented the wraparound model in 2014 and is the only provider of HFW in the state of South Carolina.

Home Delivered Meals

Prepared meals sent to a participant's residence provide a minimum of one-third of the current recommended dietary allowance, but not comprising a full nutritional regimen. These can be hot, shelf-stable, refrigerator-fresh, or blast-frozen meals.

Independent Living Skills

Services that develop, maintain and improve the community-living skills of a waiver participant. The service includes direct training from a qualified staff person to address the identified skill development needs of a waiver participant in the areas of:

- communication skills;
- community living and mobility;
- interpersonal skills;
- reduction/elimination of problem behavior;
- self-care; and
- sensory/motor development involved in acquiring functional skills.

Individual Directed Goods and Supplies

Individual directed goods and services are services, equipment or supplies not otherwise provided through this waiver or through the Medicaid State Plan that addresses an identified need in the person-centered plan in service of improving and maintaining the participant opportunities for full membership in the community.

Individual directed goods and services must meet the following requirements: the item or service decreases the need for other Medicaid services; and/or promotes inclusion in the community; and/or increases the participant's safety in the home environment; and funds to purchase the item or service is not available through another source. Experimental or prohibited treatments are excluded. Individual directed goods and services must be documented in the person-centered plan.

The services under this waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

The goods and services purchased under the authority must be documented and clearly linked to an assessed participant need established in the service plan.

In-Home Supports (Self-Directed)

Care, supervision, teaching and/or assistance provided directly to or in support of the participant and provided in the participant's home, family home, the home of others, and/or in community settings. Community activities that originate from the home will be provided and billed as in-home support. These services are necessary to enable the person to live in the community by enhancing, maintaining, improving or decelerating the rate of regression of skills necessary to continue to live in the community.

If the caregiver or participant incurs cost for vehicle operation to or from activities or other transportation costs, additional reimbursement beyond the payment of the hourly rate paid to the in-home support provider will not be made

Nurse Care Coordination

For MCC participants, nurse care coordination is to assist participants in facilitating access to health services; promoting continuity of care; improving health, developmental, psychosocial and functional outcomes; maximizing efficient and effective use of resources; gaining access to skilled medical monitoring, and intervention to maintain the participant through home support.

Minimum limits of:

- Face-to-face - quarterly
- Telephone contact - monthly

Care advocate contact is contact by a professional who assists nurse care coordinators by facilitating access to health services and interventions to maintain the participant through home support.

Nursing Services

Individual and continuous care (in contrast to part time or intermittent care) provided by licensed nurses within their scope of practice in the state's Nurse Practice Act. These services are provided to a participant in their home. Continuous and individual skilled care is provided by a licensed registered nurse or a licensed practical nurse, under the supervision of a registered nurse, licensed in accordance with the state's Nurse Practice Act, and in accordance with the participant's plan of care as deemed medically necessary by an authorized health care provider. Services are not allowed when a participant is in an institutional setting.

Occupational Therapy

Occupational therapy is a treatment used to restore or improve fine motor functioning.

Pediatric Medical Day Care

Services furnished on an hourly basis, or as specified in the person-centered service plan, in a licensed, integrated, community-based setting, encompassing both health and social services needed to ensure the optimal functioning of the participant. Meals provided as a part of these services shall not constitute a full nutritional regiment (3 meals per day).

Peer Guidance for Participant-Directed Care

Peer guidance for participant-directed care is information, advice, and encouragement provided by a peer to a participant with severe cognitive and/or severe physical impairment to recruit, train, and supervise caregivers.

Personal Care Services (PCS)

Active, hands-on assistance in the performance of Activities of Daily Living (ADLs) or Instrumental Activities of Daily Living (IADLs) provided to the waiver participant in or outside

their home. Personal care services can be provided on a continuing basis or on episodic occasions. Under no circumstances will any type of skilled medical service be performed by an aide.

Personal Emergency Response System (PERS)

This service involves installation of the Personal Emergency Response System (PERS). The unit must have three components: 1. small radio transmitter (a help button carried or worn by the user) 2. A console when emergency help (medical, fire, or police) is needed 3. Emergency Response Center to determine the nature of the calls. The service includes installation, participant instruction and maintenance of devices/systems. The service includes monitoring. The response center is staffed by trained professionals twenty-four hours a day, seven days a week

Pest Control Treatment

Pest control includes services to remove pests, such as cockroaches, from a participant's residence. Services are provided based on the demonstrated need to ensure participant's health, safety and welfare. Providers inspect participant's residence, confirm existent pests, and treat the residence (interior and exterior) to eliminate infestation.

Service does not include snakes, termites, or rodent removal.

Pest Control – Bed Bugs

Pest control- bed bug services aid in maintaining an environment free of bed bugs to enhance safety, sanitation, and cleanliness of the participant's home or residence. The Provider must obtain an authorization from participant's WCM to designate the amount, frequency and duration of service for participants. All instructions on the authorization for service must be followed in order to be reimbursed for the pest control service. Pest control services for bed bugs must be completed by the provider within 14 days of acceptance of the WCM authorization for service. For bed bugs all providers must go into the participant's home/or residence to inspect and treat the participant's home/or residence. A responsible adult who is eighteen years of age or older must be at the participant's home/or residence at the time of the treatment or the provider will need to reschedule for a time when the responsible adult who is eighteen years of age or older will be present at the participant's home/or residence.

Services are limited to one time per year. This service does not apply to provider-owned or controlled residential settings. Pest control-bed bug services are secured through a bid process with award given to the lowest bid, subject to $1,000 cap per treatment.

Physical Therapy

Physical therapy (PT) is a treatment to prevent, alleviate, or compensate for movement and/or mobility impairments, motor dysfunction, and related functional problems resulting from physical injury or illness. It uses physical agents, mechanical methods/devices, and other remedial treatments to restore or improve functioning. The service includes evaluation,

therapy sessions, and consultation with caregivers or service providers. PT funded by HASCI waiver is an extended state plan service.

Private Vehicle Modifications

Modifications to a privately owned vehicle to be driven by or routinely used to transport SCDDSN Waiver participants. It may include any equipment necessary to make the vehicle accessible to the participant. Modifications of a vehicle owned by a publicly funded agency are not permitted. Modifications can include follow-up inspections, training in the use of equipment, repairs not covered by warranty, and replacement of parts or equipment. The approval process for private vehicle modifications is initiated based upon the needs specified in the participant's Support Plan and following confirmation of the availability of a privately owned vehicle to be driven by or routinely used to transport the participant. The approval process is the same for any private vehicle modification, regardless of ownership. Each request must receive prior approval following programmatic and fiscal review and shall be subject to the state procurement act. Programmatic approval alone may be given for the emergency repair of equipment to ensure safety of the participant. These modifications are in order to accommodate the special needs of the participant

Private Vehicle Assessment/Consultation

Private vehicle assessment/consultation may be provided once a SCDDSN participant's specific need has been identified and documented in the Support Plan. The scope of the work and specifications must be determined. The criterion used in assessing a participant's need for this service are: 1) The parent or family member cannot transport the individual because the individual cannot get in or out of the vehicle; or 2) the individual can drive but cannot get in or out of the vehicle and a modification to the vehicle would resolve this barrier. Private vehicle assessment/consultation may include the specific modifications/equipment needed, any follow-up inspection after modifications are completed, and training in use of equipment. The consultation/assessment does not require submission of bids. Private Vehicle Assessments/Consultations can be completed by Licensed Medicaid enrolled Occupational or Physical Therapists, Medicaid enrolled Rehabilitation Engineering Technologists, Assistive Technology Practitioners and Assistive Technology Suppliers certified by the Rehabilitation Engineering Society of North American (RESNA), Medicaid enrolled Environmental Access/Consultants/contractors or vendors who are contracted through the DSN Board to provide the service. The reimbursement for the Consultation/Assessment may not exceed $600.00

Psychological Services

Psychological services address the affective, cognitive, and substance abuse problems of a HASCI waiver participant aged 21 years or older. This service includes psychiatric, psychological, and neuropsychological evaluation; development of treatment plans; participant/family counseling to address the participant's affective, cognitive, and substance abuse problems; cognitive rehabilitation therapy; and alcohol/substance abuse counseling.

Respite Care

Short-term services provided because a support person is absent or needs relief provided in

a person's home or apartment when relieving the support person is the primary purpose of the service.

Institutional Respite Care

Short-term services provided because a support person is absent or needs relief. Services expressly are not provided in a person's home or apartment when relieving the support person is the primary purpose of the service.

Residential Habilitation

Residential Habilitation is the care, supervision and skills training provided to a person in a non- institutional setting. The type, scope and frequency of care, supervision, and skills training to be furnished are described in the person's service plan and are based on his/her assessed needs and preferences. Services furnished as Residential Habilitation must support the person to live as independently as possible in the most integrated setting that is appropriate to his/her needs.

The care provided as part of Residential Habilitation may include but is not limited to assistance with personal care, medication administration, and other activities that support the person to reside in his/her chosen setting.

The type and level of supervision provided as part of Residential Habilitation must be proportionate to the specific needs and preferences of the person.
The skills training provided as part of Residential Habilitation may include but is not limited to the following: adaptive skill building, activities of daily living, community inclusion, access and use of transportation, educational supports, social and leisure skill development and other areas of interest /priorities chosen by the person.

Payments for Residential Habilitation are not made for room and board, the cost of facility maintenance, upkeep and improvement, other than such costs for modifications or adaptations to a facility required to assure the health and safety of residents. Payment for Residential Habilitation does not include payments made, directly or indirectly, to members of the individual's immediate family. Payments will not be made for the routine care and supervision which would be expected to be provided by a family or group home provider, or for activities or supervision for which a payment is made by a source other than Medicaid. Provider controlled, owned or leased facilities where Residential Habilitation services are furnished must be compliant with the Americans with Disabilities Act.

Participants who receive Residential Habilitation paid at a daily rate are not allowed to receive the Adult Companion service.

The 8 tiers for the daily residential habilitation service are as follows:
1. High Management (Intensive Support Residential Habilitation);
2. Tier 4 (Intensive Support Residential Habilitation);
3. Tier 3 (Intensive Support Residential Habilitation);
4. Tier 2;
5. Tier 1;
6. Supervised Living Program (SLP) II;

7. CTH I Tier 2; and
8. CTH Tier 1.

SLP I is a separate hourly rate for residential habilitation services.

*High Management (Intensive Support Residential Habilitation) is delivered through the Community Training Home II (CTH II) model which is shared by up to three (3) people who have a dual diagnosis of intellectual disability and mental illness or those who have a diagnosis of intellectual disability and display extremely challenging behaviors.

*Tier 4 (Intensive Support Residential Habilitation) is delivered through the CTH-II model which is shared by up to four (4) people who may have been involved with the criminal justice system and individuals with severe behaviors requiring heightened staffing levels.

*Tier 3 (Intensive Support Residential Habilitation) is delivered through the CTH-II model which is shared by up to four (4) people or CRCF model which is shared by up to twelve (12) people who have a dual diagnosis of intellectual disability and mental illness or those who have a diagnosis of intellectual disability and display extremely challenging behaviors. Includes people being discharged from a SCDDSN Regional Center (ICF/IID) or community ICF/IID. Also includes people who need additional supports to prevent or delay institutional placement and to participate in community life due to behavioral health concerns, physical health conditions, medical support needs, and/or limitations in physical abilities which impact the person's ability to perform Activities of Daily Living without support from another.

*Tier 2 is delivered through the CTH-II model which is shared by up to four (4) people or CRCF model which is shared by up to twelve (12) people. It includes people who need additional supports (greater than included in Tier 1) to prevent or delay institutional placement and to participate in community life due to: behavioral health concerns, physical health conditions, medical support needs, and/or limitations in physical abilities which impact the person's ability to perform Activities of Daily Living without support from another.
*Tier 1 is delivered through the CTH-II model which is shared by up to four (4) people or CRCF model which is shared by up to twelve (12) people. It includes people who need support to live in and participate in their community. Those supports include a degree of care, supervision, and skills training provided throughout the day.

*Supervised Living Program (SLP) II: includes people who need support to live in and participate in their community. The supports delivered include a degree of care, supervision, and skills training provided throughout the day. SLP II is delivered in a licensed SLPII setting that is typically single or double-occupancy residence.

*CTH Tier 2: delivered to waiver participants who need additional supports (greater than included in CTH Tier) to enable them to live in the setting and participate in community life due to: behavioral health concerns, physical health conditions, medical support needs, and/or limitations in physical abilities which impact the person's ability to perform activities of daily living without support. Those additional supports are typically services/supports specifically intended to provide relief/assistance to the supports provider and are necessary due to the amount/intensity of supports the person requires. CTH Tier 2 services are delivered to up three (3) people in the CTH I licensed home of the support provider.

*CTH Tier 1: delivered to waiver participants who need support to live in and participate in their community. CTH Tier 1 services are delivered to up three (3) people in the CTH I licensed home of the support provider.

*SLP I: delivered to waiver participants who need support in their own apartment or home setting. Support is provided through a 15-unit and support is available 24 hours per day by phone. An annual assessment is completed for each participation to verify support needs in their own setting.

*Tier 1 is delivered through the CTH-II model which is shared by up to four (4) people or CRCF model which is shared by up to twelve (12) people. It includes people who need support to live in and participate in their community. Those supports include a degree of care, supervision, and skills training provided throughout the day.

*Supervised Living Program (SLP) II: includes people who need support to live in and participate in their community. The supports delivered include a degree of care, supervision, and skills training provided throughout the day. SPL II is delivered in a licensed SLPII setting that is typically single or double-occupancy residence.

*CTH Tier 2: delivered to waiver participants who need additional supports (greater than included in CTH Tier) to enable them to live in the setting and participate in community life due to: behavioral health concerns, physical health conditions, medical support needs, and/or limitations in physical abilities which impact the person's ability to perform activities of daily living without support. Those additional supports are typically services/supports specifically intended to provide relief/assistance to the supports provider and are necessary due to the amount/intensity of supports the person requires. CTH Tier 2 services are delivered to up three (3) people in the CTH I licensed home of the support provider.

*CTH Tier 1: delivered to waiver participants who need support to live in and participate in their community. CTH Tier 1 services are delivered to up three (3) people in the CTH I licensed home of the support provider.

*SLP I: delivered to waiver participants who need support in their own apartment or home setting. Support is provided through a 15-unit and support is available 24 hours per day by phone. An annual assessment is completed for each participation to verify support needs in their own setting.

Respite Care in a Community Residential Care Facility

Short-term services provided because a support person is absent or needs relief provided in a Community Residential Care Facility (CRCF) when relieving the support person is the primary purpose of the service.

Total participant days allowed per fiscal year (July 1 – June 30) is limited to twenty-eight (28) for some waivers. This includes any institutional respite days, if applicable.

Skilled Respite

Respite services provided to participants unable to care for themselves and furnished on a short-term basis because of the absence or need for relief of those persons who normally provide care for the participant. Skilled respite services will be offered to those children needing skilled care undersigned physician orders. For skilled respite, either a RN or LPN may provide this service such as, checking vitals, administering medication and medical supervision. Unskilled respite services will be offered to those children with only unskilled care (ADL's and IADL's) needs provided by a personal care aide.

The location(s) where respite care can be provided include, for example, the participant's home or private place of residence, the private residence of a respite care provider, a foster home, or a Medicaid certified hospital.

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Specialized Medical Equipment, Supplies and Assistive Technology

Specialized medical equipment and supplies include: (a) devices, controls, or appliances, specified in the plan of care, that enable participants to increase their ability to perform activities of daily living; (b) devices, controls, or appliances that enable the participant to perceive, control, or communicate with the environment in which they live; (c) items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items; (d) such other durable and non-durable medical equipment not available under the state plan that is necessary to address participant functional limitations; and, (e) necessary medical supplies not available under the state plan. Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the state plan and exclude those items that are not of direct medical or remedial benefit to the participant. All items shall meet applicable standards of manufacture, design and installation. Items available in this service include nutritional supplements and handheld shower.

Providers must fill orders from their own inventory or contract with other companies for the purchase items necessary to fill the order. Providers must notify participants of warranty coverage and honor all warranties under applicable state law, and repair or replace free of charge SMA-covered items that are under warranty. In addition, providers must employ adequate staff to coordinate service delivery, package products according to service authorizations, and respond to complaints and grievances received from participants.

This service is limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

Specialized Medical Equipment, Supplies, and Assistive Technology

Specialized medical equipment, supplies and assistive technology to include devices, controls, or appliances, specified in the plan of care which enable individuals to increase their abilities to perform activities of daily living or to perceive, control, or communicate with the environment in which they live. This service also includes items necessary for life support, remote supports, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the

Medicaid State plan. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State plan and shall exclude those items which are not of direct medical or remedial benefit to the individual. All items shall meet applicable standards of manufacture, design and installation.

Items covered through remote supports are medication dispensers, door sensors, window sensors, stove sensors, water sensors, pressure pads, GPS Tracking Watches and the remote monitoring equipment necessary to operate the remote supports technology. These remote support items will be “placed” in accordance with the specific item type (medication dispensers in the location selected by the person, door sensors on doors, window sensors on windows, stove sensors on stove, water sensors on faucets, pressure pads on the person’s bed/chair, and GPS tracking watches would be worn by the individual). Video cameras/monitors will not be included or allowed as part of the service. The individual has the ability to turn/take off the remote support equipment at his/her discretion. Remote supports will assist with preserving the individual’s independence in his/her living environment through the implementation of technology which will in turn lessen the requirement for supervision with tasks such as taking medication and cooking, while maintaining the person’s safety. Remote supports allow the person dignity of risk and the ability to manage their lives more independently. For example, the GPS tracking watch allows the person to independently access the community, and arrive at their planned location, while at the same time, allowing their designated responder the ability to ensure their safe arrival at the destination. Remote supports are limited to waiver participants who have natural supports willing to be identified as designated responders. As such, the person responsible for responding will be the natural support identified by the waiver participant and will be on-call. The participant must designate the remote supports responder, which allows him/her to select someone he/she is comfortable with. Only the designated responder will have access to information generated from the remote support, and the person can elect to terminate the designees’ access and name an alternate responder at any point.

Per the outlined service, the remote supports provider is required to inform the participant, and anyone identified by the participant, of what impact the remote supports will have on the participant’s privacy. This information must be provided to the participant in a form of communication understood by the participant.

After this has been completed, the remote supports provider must obtain either the participant’s consent in writing or the written consent of a legally responsible party for the participant. This process must be completed prior to the utilization of remote supports and any time there is a change to the devices or services. This information will be provided to the participant and service plan team for discussion and inclusion of the Remote Supports in the Support Plan.

The case manager’s monitoring of the service and its effectiveness will ensure the individual’s needs are being met and health and welfare needs are being addressed.

As with all waiver services, back-up plans are necessary to ensure the participant’s health and welfare. Natural supports must be identified to assist in the event of an equipment/technology failure.

All technology will be evaluated to ensure it meets HIPPA requirements prior to use,

and policy will include requirements that this be vetted in advance as part of person-centered service planning. The state will include review of the proposed methodology by the HIPAA compliance officer(s) prior to implementation of the service. The limit is 2 cases per month of liquid nutrition for waiver participants without a feeding tube. Liquid nutrition for waiver participants on a feeding tube is provided by Medicaid State Plan and is not covered by the waiver.

Specialized Medical Equipment, Supplies and Assistive Technology Assessment/Consultation

Specialized medical equipment, supplies, and assistive technology assessment/consultation may be provided (if not covered by Medicaid State Plan) to determine specific needs related to the participant's disability for which specialized medical equipment and assistive technology will assist the participant to function more independently.

Speech and Hearing Services

Speech and hearing services funded by the HASCI waiver is an extended state plan service. Speech and hearing services are treatments to alleviate or compensate for speech and hearing impairments resulting from physical injury or illness. It includes the full range of activities provided by a licensed speech-language pathologist or a licensed audiologist. The service includes evaluation, development of therapeutic treatment plans, therapy sessions, training to use augmentative communication devices, and consultation with caregivers or service providers. Medicaid State Plan provides medically necessary private rehabilitative therapy and audiological services to children under the age of 21 years. This includes speech-language pathology services and audiology services. The HASCI waiver makes the same benefits available to adults aged 21 years and older.

Support Center Services

Support center services include non-medical care, supervision and assistance provided in a non-institutional group setting outside of the participant's home to individuals who, because of their disability, are unable to care for and supervise themselves. Services provided are necessary to prevent institutionalization and maintain the participant's health and safety. The care, supervision and assistance will be provided in accordance with a plan of care. An array of non-habilitative activities and opportunities for socialization will be offered throughout the day but not as therapeutic goals. Activities can occur in natural settings that do not isolate participants from others without disabilities.

Transportation will be provided from the individual's residence to the service provision site when the service starts before 12:00 noon. Transportation will be available from the individual's service provision site to his/her residence when the service start time is after 12:00 noon. The cost for transportation is included in the rate paid to the provider.

Transition Coordination

Transition coordination provides assistance with the transition process to Home Again participants. The transition coordination service will support the participants to make a successful transition into the community. The transition coordination service will also ensure

continued access to appropriate and available services for participants to remain in the community. Transition coordination is available as a Home Again grant funded service.

Tele-Monitoring

Monitoring service utilizing technologies which measure and report the health status of at-risk waiver participants. This is done remotely by utilizing either existing telephone infrastructure or wireless communication technology in collecting and transmitting physiological data between the provider and participant. Monitoring is the primary purpose of this service. Remote monitoring will assist the individual to fully integrate into the community, participate in community activities, and avoid isolation.

Participants receiving the telemonitoring service must have a primary care physician that approves the use of the telemonitoring service and is solely responsible for receiving and acting upon the information received via the telemonitoring service.

Telemonitoring equipment located in the participant's home must, at a minimum, be an FDA Class II Hospital grade medical device that includes a computer/monitor that is programmable for a variety of disease states and for rate and frequency. The equipment must have a digital scale that measures accurately to at least 400 lbs. that is adaptable to fit a glucometer and a blood pressure cuff. All installed equipment must be able to measure, at a minimum, blood pressure, heart rate, oxygen saturation, blood glucose, and body weight. Telephones, facsimile machines, and electronic mail systems do not meet the requirements of the definition of telemonitoring but may be utilized as a component of the telemonitoring system. As communication of data occurs at scheduled daily "appointment times" and the information collected/sent is neither visible to others or remains stored on the device, the participant maintains constant control of their personal information within the residential environment.

Waiver Case Management (SCDDSN)

Services that assist participants in gaining access to needed waiver and other State Plan services, regardless of the funding sources for the services to which access is gained. Waiver case managers are responsible for initiating and/or conducting the process to evaluate and/or re-evaluate the individual's level of care as specified in waiver policy. Waiver case managers are responsible for conducting assessments and developing service plans as specified in waiver policy. This includes the ongoing monitoring of the provision of services included in the participant's service plan.

Waiver case managers are responsible for the ongoing monitoring of the participant's health and welfare, which may include crisis intervention and referral to non-waiver services.

The waiver also includes transitional waiver case management. Transitional WCM is used when a person in an institutional setting is being discharged from the setting and entering a waiver program. Persons served under the waiver may receive case management services while they are still institutionalized, for up to 180 consecutive days prior to discharge. The state can choose a limit of less than 180 days.

Unskilled Respite

In-home respite services provide temporary care in the home for Medically Complex Children and PCSC waiver participants living at home and cared for by their families or other informal support systems. These services maintain participants and provide temporary relief for the primary caregivers.

6

UTILIZATION MANAGEMENT

PRIOR AUTHORIZATION

For general policies regarding Program Integrity, Utilization Management, Fraud, Waste and Abuse, providers must refer to the Provider Administrative and Billing Manual.

For specific information regarding SCDDSN operated waiver services, please see https://ddsn.sc.gov/. For SCDDSN-operated waiver services, service authorization will be transmitted through SCDDSN approved methods.

Prior Authorization for SCDHHS Operated Waivers

Authorization of Services

Services must be prior authorized by the CM or CC based on the participant's plan of service. Prior authorizations are required for most waiver services.

Authorization will be transmitted to the provider by the completion of an SCDHHS Service Provision Form (DHHS Form 175). Accompanying the authorization will be a copy of the plan of service and, if appropriate, a copy of the prescriber's order.

Participant Choice of Providers

SCDHHS-operated waiver participants are required to choose a service provider from a Service Provider Report, which lists available providers of each service for the participant's waiver of participation. The Participant Choice of Provider(s) Form will identify the referring entity and SCDHHS provider(s) already involved in the care of the participant. The following services require a preferred provider to participate in a bid process and are excluded from this policy: Environmental modifications and private vehicle modifications. For bid process services, the provider submitting the lowest bid will be awarded the referral. If the provider submitting the lowest bid cannot provide the service, the referral will be awarded to the next lowest bidder.

Authorization Periods

Authorizations are issued for most waiver and state plan services described in this manual indicating the beginning date of the service, and the number of units of service to be provided. Frequency varies depending on the type of service. Please see scope of service for authorization guidelines for each service The hours of service will be indicated only if specific times are essential to meeting the participant's service needs.

For personal care and companion services authorized by SCDHHS, the authorization will designate the days of the week that the service is to be provided during the morning, afternoon, or evening. If the authorization indicates multiple times of day this indicates that the participant requires services more than one time a day. The authorization period ending date may or may not be indicated on the service provision form. Authorizations without an ending date will be valid

until a revised service provision form is issued to the provider.

Changes in Services Within an Authorization Period

If the participant's needs change during an authorization period, a revised service provision form will be sent to the provider. Changes in frequency of a particular service do not require a new prescriber's order.

Interruption of Services

Previously authorized services will be placed on hold if the participant enters a hospital or institution for a temporary stay or temporarily chooses not to receive services. The interruption of services does not require a revised service provision form unless the service is to be interrupted for a full calendar month.

Termination of Authorized Services

Services must be officially terminated whenever it is determined that the participant no longer requires an authorized service, and when a participant is disenrolled from a waiver. Both the participant and the provider must be notified of the termination of services. This verbal notification must be followed with a written confirmation of termination of the service, including written guidance for how to appeal the action.

Hospice and HCBS Interaction (for the Community Choices (CC), Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS), and Mechanical Ventilator Dependent waiver (Vent) waivers only)

For additional information related to the hospice providers' role in prior authorization and the interaction between hospice and HCBS please refer to Section 6 of the Hospice Provider Manual.

If the hospice provider determines that HCBS are in place for a beneficiary electing hospice benefits, the hospice provider must contact the HCBS provider(s) within two business days of the beneficiary electing hospice to:

1. Coordinate with the HCBS provider in developing the hospice plan of care.

2. Coordinate scheduling of services.

3. Initiate the Hospice-HCBS Coordination Form 160, complete the appropriate sections related to the provision of hospice service, and send to the HCBS provider to complete the appropriate sections related to the provision of HCBS.

4. Provide the HCBS provider with a copy of the beneficiary's hospice POC and copies of any updated plans for care. This allows for better communication with the beneficiary and family during the hospice admission visit to outline the differences in services.

HCBS direct care providers must:

1. Work with the hospice provider to coordinate the scheduling of services,

2. Complete the required sections of the Hospice-HCBS Coordination Form 160 related to the provision of HCBS, verifying that the hospice prior authorization number is included.

3. Send a copy of the completed form and the copy of the beneficiary's HCBS person-centered service plan to the hospice provider within two (2) business days of receipt.

4. Maintain a copy of the form in the HCBS provider's record for the beneficiary.

5. The HCBS provider must maintain a copy of the beneficiary's most current hospice POC and Hospice-HCBS Coordination Form 160 in the beneficiary's record.

Change in HCBS Provider

Should the beneficiary choose a new HCBS provider for services, the hospice provider must contact the new HCBS provider within 2 business days to initiate and complete the required process above for coordination of services.

The hospice provider and HCBS provider must coordinate tasks and services as well as the time of day that the beneficiary may receive visits from each provider's direct care workers. Hospice and HCBS providers must coordinate to ensure direct care service hours do not overlap. The hospice provider and the HCBS provider will instruct direct care workers that if they arrive at the home and the other provider's direct care worker is there, they must report this to their respective providers administration and leave the home. Any changes in scheduling for either of the providers must be reported to the other to avoid duplication/overlap of services. Services provided at the same time by hospice and HCBS providers are subject to recoupment. Two providers cannot provide the same service at the same time (e.g. Personal Care and Nursing).

HCBS Case Manager Role

Hospice providers must submit the completed **Hospice-HCBS Coordination Form 160** to the waiver case manager within five (5) business days of hospice election and maintain a copy in the hospice provider's medical record for the beneficiary.

Upon receipt of the HCBS Coordination Form /SCDHHS Hospice Form 160 from the hospice provider, the waiver case manager must complete the following:

1. Review the beneficiary's authorization(s) for services and make any needed changes/updates.

2. Update the HCBS person-centered service plan to include the participant's enrollment in hospice services.

3. Update Participant Information section of Phoenix to reflect "Prior Authorization number" of hospice provider (i.e., HSP number listed on Form 160).

4. Upload a copy of the Form 160 into Phoenix under the Hospice Forms.

Should the beneficiary choose a new HCBS provider for services the waiver case manager must contact the hospice provider to notify them of the change and provide the hospice provider with the new HCBS provider's contact information. Should the beneficiary revoke the hospice election, or the hospice provider discharge the beneficiary, the case manager must:

1. Update service plan to remove hospice enrollment.

2. Update Participant Information section to remove Prior Authorization number of the hospice provider.

For specific information regarding SCDDSN waiver services, please see https://ddsn.sc.gov/.

7
REPORTING/DOCUMENTATION

General policies for Medicaid beneficiaries' health records requirements and documentation are detailed in the Provider Administrative and Billing Manual. In addition to the general policies, HCBS providers must comply with specific policies for participant and employee records requirements and documentation in their Scopes and Standards.

HIPAA Confidentiality Requirements

Providers must maintain records per the HIPAA Confidentiality Requirements as outlined in the Administrative and Billing Manual. Records must be maintained in a secure manner to ensure the maintenance of confidentiality.

Signature Policy

The signature of the provider rendering or authorizing the services may be handwritten, electronic or digital. Stamped signatures are unacceptable. For acceptable electronic signatures, refer to the SCDHHS Provider Administrative and Billing Manual, section "Electronic Signatures".

Electronic Record Keeping

Providers can utilize electronic record keeping methods. Providers must ensure that they utilize a backup storage system. The provider must also ensure that all scope requirements can be met in the electronic record-keeping system.

Mandatory Reporter

In accordance with the S. C. Code of Laws, § 43-35-25, HCBS providers and their staff are mandatory reporters of abuse, neglect or exploitation of vulnerable adults. Allegations must be reported to the South Carolina Department of Social Services (SCDSS) within twenty-four (24) hours or within the next business day of receipt of the allegation or of witnessing the abuse, neglect or exploitation. Reports must be made in writing, or orally by telephone or otherwise.

HCBS providers and their staff are also mandatory reporters of abuse, neglect, or exploitation of children when in a professional capacity under S.C. Code of Laws, § 63-7-310. HCBS providers and their staff must report any information received that suggests the following:

- The reporter believes a child has been or may be abused or neglected as defined in § 63-7-20
- The reporter believes a child's physical or mental health or welfare has been or may be adversely affected by acts or omissions considered to be child abuse or neglect if committed by a responsible party (parent, guardian, or other person responsible for

the child's welfare), but the acts or omission were committed by a person other than a responsible party. The reporter must notify the appropriate law enforcement agency.

Reports of child abuse or neglect may be made orally by telephone or otherwise to the Department of Social Services county office or to a law enforcement agency in the county where the child resides or is found.

8

BILLING GUIDANCE

ELECTRONIC VISIT VERIFICATION (EVV) AND PHOENIX BILLING PROCEDURES AND SERVICE MONITORING

The provider must agree to participate in all components of SCDHHS' Electronic Visit Verification (EVV) system or Phoenix monitoring and payment system when providing services for participants of the CC, HIV/AIDS, Vent, and MCC waivers. The EVV system is an automated system used for service documentation and Medicaid Management Information System (MMIS) billing. Phoenix is a system that is used for service monitoring, web-based reporting, and billing to MMIS.

For monitoring service delivery and reporting, real-time reports allow providers, case managers, and/or nurses to monitor participants more closely to ensure receipt of services. The EVV system generates electronic billing to MMIS for services provided 6 days a week. Only authorized services and the total units provided (up to the maximum authorization) are submitted to MMIS for payment. If resolutions are submitted for billing through Phoenix, they must be uploaded in Phoenix within 2 weeks of service delivery to receive payment without a worker strike per the Strike Policy. This billing ensures accuracy of claim processing.

SCDHHS reserves the right to perform onsite reviews during normal business hours to ensure compliance with policies and procedures.

Medicaid Web-based Claim Submission Tool Billing Procedures

The ID/RD, CS and HASCI waivers currently do not require the use of the EVV billing system and claims may be submitted electronically via the South Carolina Medicaid Web-based Claim Submission Tool.

Providers will be required to bill claims on this website in a timely manner. Claims, at a minimum, must be entered into the website within the quarter after the date of service. In all cases, services documented are compared with prior authorizations in the system to determine if the services were provided appropriately. Claims rejected for payment must be resubmitted through the local SCDHHS area office.

For additional information regarding billing please see the following:

Strike Policy

Medicaid Web Tool Training