Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a state to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waivers target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the state, service delivery system structure, state goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

Request for an Amendment to a §1915(c) Home and Community-Based Services Waiver

1. Request Information

A. The **State** of **South Carolina** requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act.

B. Program Title:
Palmetto Coordinated System of Care for Children (PCSC) Home and Community Based Waiver

C. Waiver Number:SC.1686

D. Amendment Number:SC.1686.R00.02

E. Proposed Effective Date: (mm/dd/yy)
05/01/21

Approved Effective Date: 06/24/21
Approved Effective Date of Waiver being Amended: 08/01/20

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:

The primary purpose of the amendment is to grant the SC Department of Children's Advocacy, Continuum of Care Division, hereafter identified as Continuum of Care and COC, operating authority thereby assigning responsibility to work collaboratively with the Medicaid agency to ensure the waiver operates in accordance with waiver requirements. Specific areas of collaboration include:
*Participant waiver enrollment.
*Waiver enrollment managed against approved limits.
*Level of care evaluation.
*Review of participant service plans.
*Prior authorization of waiver services.
*Utilization management.
*Qualified Provider enrollment.
*Rules, policies procedures and information development governing the waiver program.
*Quality assurance and quality improvement activities.

The secondary purpose of the amendment is to change the financial management service provider type from an Agency with Choice to a Single Entity. The State has also revised performance measures to incorporate new guidance and to delegate data collection responsibilities in accordance with the change in operating entity.

3. Nature of the Amendment

A. Component(s) of the Approved Waiver Affected by the Amendment. This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently *(check each that applies):*

Component of the Approved Waiver	Subsection(s)
☒ **Waiver Application**	1C, 2, 6I, 7B
☒ **Appendix A Waiver Administration and Operation**	A1, A2, A3, A4, A7, QIS
☒ **Appendix B Participant Access and Eligibility**	B6b, f, QIS Sub-assurance a
☒ **Appendix C Participant Services**	QIS Sub-assurances b and c
☒ **Appendix D Participant Centered Service Planning and Delivery**	D1d, e, g, D2a, QIS Sub-assurances a, c and d
☒ **Appendix E Participant Direction of Services**	E1a, d, i, j, l, m
☐ **Appendix F Participant Rights**	
☒ **Appendix G Participant Safeguards**	G3b-c, QIS Sub assurances a, b and c
☐ **Appendix H**	
☐ **Appendix I Financial Accountability**	
☐ **Appendix J Cost-Neutrality Demonstration**	

B. Nature of the Amendment. Indicate the nature of the changes to the waiver that are proposed in the amendment *(check each that applies):*

☐ **Modify target group(s)**

☐ **Modify Medicaid eligibility**

☐ **Add/delete services**

☐ **Revise service specifications**

☐ **Revise provider qualifications**

☐ **Increase/decrease number of participants**

☐ **Revise cost neutrality demonstration**

☐ **Add participant-direction of services**

☒ **Other**

Specify:

The amendment delegates operating authority to the Continuum of Care (COC), modifies the provider type category for the financial management services vendor for the provision of individual directed goods and services, and revised select performance measures based on recent guidance.

Application for a §1915(c) Home and Community-Based Services Waiver

1. Request Information (1 of 3)

A. The **State** of **South Carolina** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. Program Title (*optional - this title will be used to locate this waiver in the finder*):

Palmetto Coordinated System of Care for Children (PCSC) Home and Community Based Waiver

C. Type of Request: amendment

Requested Approval Period:*(For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)*

○ **3 years** ◉ **5 years**

Waiver Number:SC.1686.R00.02
Draft ID: SC.020.00.02

D. Type of Waiver *(select only one):*

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 08/01/20
Approved Effective Date of Waiver being Amended: 08/01/20

PRA Disclosure Statement

The purpose of this application is for states to request a Medicaid Section 1915(c) home and community-based services (HCBS) waiver. Section 1915(c) of the Social Security Act authorizes the Secretary of Health and Human Services to waive certain specific Medicaid statutory requirements so that a state may voluntarily offer HCBS to state-specified target group(s) of Medicaid beneficiaries who need a level of institutional care that is provided under the Medicaid state plan. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449 (Expires: December 31, 2023). The time required to complete this information collection is estimated to average 160 hours per response for a new waiver application and 75 hours per response for a renewal application, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

1. Request Information (2 of 3)

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be

reimbursed under the approved Medicaid state plan (*check each that applies*):

☒ **Hospital**

Select applicable level of care

○ **Hospital as defined in 42 CFR §440.10**

If applicable, specify whether the state additionally limits the waiver to subcategories of the hospital level of care:

◉ **Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160**

☐ **Nursing Facility**

Select applicable level of care

○ **Nursing Facility as defined in 42 CFR ??440.40 and 42 CFR ??440.155**

If applicable, specify whether the state additionally limits the waiver to subcategories of the nursing facility level of care:

○ **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**

☐ **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**

If applicable, specify whether the state additionally limits the waiver to subcategories of the ICF/IID level of care:

1. Request Information (3 of 3)

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:

○ **Not applicable**

◉ **Applicable**

Check the applicable authority or authorities:

☐ **Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**

☒ **Waiver(s) authorized under §1915(b) of the Act.**

Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

A 1915(b)(4)waiver application has been submitted for approval.

Specify the §1915(b) authorities under which this program operates *(check each that applies):*

☐ **§1915(b)(1) (mandated enrollment to managed care)**

☐ **§1915(b)(2) (central broker)**

☐ **§1915(b)(3) (employ cost savings to furnish additional services)**

☒ **§1915(b)(4) (selective contracting/limit number of providers)**

☐ **A program operated under §1932(a) of the Act.**

Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:

☐ **A program authorized under §1915(i) of the Act.**

☐ **A program authorized under §1915(j) of the Act.**

☐ **A program authorized under §1115 of the Act.**
Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.
Check if applicable:

☒ **This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

The State of South Carolina (State) is developing the Palmetto Coordinated System of Care (PCSC) for South Carolina's youth with significant behavioral health challenges or co occurring conditions in or at imminent risk of out of home placement. PCSC is an evidenced based approach that is part of a national movement to develop family driven and youth guided care, and keep youth at home, in school, and out of the child welfare and juvenile justice systems. The State's goal is for youth and families to receive services when needed that are designed to help participants achieve safe, healthy, and functional lives as successful, responsible, and productive citizens.

The purpose of this waiver is to provide home and community-based supports and services to youth with mental illness(es) who would otherwise be served in inpatient psychiatric hospitals. Families and youth are offered the choice of behavioral health services and supports to permit the participant to remain in, or return to, the least restrictive environment--preferably their homes. To be eligible, a potential waiver participant must meet the inpatient level of care and meet all Medicaid financial requirements.

These services are provided using a system of care approach. There is a single point of entry for all waiver applicants. Applicants are evaluated to determine eligibility for the waiver. Families and youth who enter the waiver participate in person-centered plan development meetings comprised of individuals involved with the family and any representatives the family chooses to attend. During the meeting, a person-centered plan is developed. The family may choose from a network of enrolled, qualified providers consisting of both public and private providers. If the family has a provider who they have been working with who is not an enrolled, qualified provider, efforts are made to contact the provider to discuss their interest in joining the network. The youth and family team meets at least every 90 days, or more often as needed or requested, to discuss treatment progress and any necessary or requested changes. Annual reevaluations are conducted to determine continued eligibility for waiver participation.

The services under this waiver are limited to additional services not otherwise covered under the state plan, including Early and Periodic, Screening, Diagnostic and Treatment (EPSDT), but consistent with waiver objectives of avoiding institutionalization.

The South Carolina Department of Health and Human Services (SCDHHS) seeks to selectively contract with the Continuum of Care (COC) to provide High Fidelity Wraparound services. Based on national research for children's system of care, SCDHHS will only contract with entities employing High Fidelity Wraparound supervisors and coaches credentialed by the National Wraparound Implementation Center (NWIC). This is a qualification that is outlined in the service definition and for which selective contracting will be required.

SCDHHS, as the state Medicaid agency, has administrative authority over the waiver. The South Carolina Department of Children's Advocacy, which houses the COC will perform waiver operations under a memorandum of agreement (MOA) with SCDHHS. COC has the operational responsibility for ensuring that participants are aware of their options under this waiver.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

A. Waiver Administration and Operation. Appendix A specifies the administrative and operational structure of this waiver.

B. Participant Access and Eligibility. Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the state expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. Participant Services. Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. Participant-Centered Service Planning and Delivery. Appendix D specifies the procedures and methods that the state uses to develop, implement and monitor the participant-centered service plan (of care).

E. Participant-Direction of Services. When the state provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

- (●) **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ( ) **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

F. Participant Rights. Appendix F specifies how the state informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. Participant Safeguards. Appendix G describes the safeguards that the state has established to assure the health and welfare of waiver participants in specified areas.

H. Quality Improvement Strategy. Appendix H contains the Quality Improvement Strategy for this waiver.

I. Financial Accountability. Appendix I describes the methods by which the state makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. Cost-Neutrality Demonstration. Appendix J contains the state's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. Comparability. The state requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid state plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

B. Income and Resources for the Medically Needy. Indicate whether the state requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

- (●) **Not Applicable**
- ( ) **No**
- ( ) **Yes**

C. Statewideness. Indicate whether the state requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

- (●) **No**
- ( ) **Yes**

If yes, specify the waiver of statewideness that is requested *(check each that applies)*:

- [ ] **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the state.

Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:

☐ **Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the state. Participants who reside in these areas may elect to direct their services as provided by the state or receive comparable services through the service delivery methods that are in effect elsewhere in the state.
Specify the areas of the state affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

In accordance with 42 CFR §441.302, the state provides the following assurances to CMS:

A. Health & Welfare: The state assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;

2. Assurance that the standards of any state licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements are met on the date that the services are furnished; and,

3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable state standards for board and care facilities as specified in **Appendix C**.

B. Financial Accountability. The state assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. Evaluation of Need: The state assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The state assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,

2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the state employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The state assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid state plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. Actual Total Expenditures: The state assures that the actual total expenditures for home and community-based waiver

and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the state's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: The state assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. Reporting: The state assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid state plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. Habilitation Services. The state assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. Services for Individuals with Chronic Mental Illness. The state assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the state has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the state has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including state plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. Inpatients. In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.

C. Room and Board. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the state that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. Access to Services. The state does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. Free Choice of Provider. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the state has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. Fair Hearing: The state provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the state's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. Quality Improvement. The state operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the state assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The state further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the state will implement the Quality Improvement Strategy specified in **Appendix H**.

I. Public Input. Describe how the state secures public input into the development of the waiver:

SCDHHS stakeholders from family service organizations, public child-serving agencies, private and public providers including community-based providers, and families have been involved in the development of the Palmetto Coordinated System of Care (PCSC) program from the beginning. Their participation in stakeholder sessions began in 2011 when the State received its first SAMHSA system of care grant and is ongoing. As of January 2016, SCDHHS has held over 170 meetings to discuss the goals of the program and to receive feedback on the benefit and system design. The workgroups that have formed over the last several years include the following: Service Array, Ongoing Family Involvement, Provider Capacity and Training, Outcome Measures, Peer Support, Building Bridges Initiative Advisory Board, Cultural and Linguistic Competency, Communications, Planning Group, Leadership Team, and the Joint Council on Children and Adolescents. The groups met either monthly or quarterly beginning in 2013 with several continuing to meet with SCDHHS on a regular basis. A detailed list of each workgroup, along with their task, composition and meeting dates is available upon request from SCDHHS.

SCDHHS held several stakeholder sessions specifically related to the 1915(c) waiver on June 6, June 8, June 13, and June 15, 2017. A live webinar was also held on June 6, 2017. The purpose of the meetings and webinar was to receive public input according to the federal requirements. SCDHHS initiated a second period of pubic input on Feb. 6, 2020. The public comments have been reviewed and are reflected in the final submission to CMS. Public comments and responses can be found at this link:
https://www.scdhhs.gov/sites/default/files/PCSC%20Waiver%20Public%20Comments%20and%20Responses%3B%20FINAL.3.25

In addition to continuing to meet with stakeholder groups, SCDHHS utilizes its website, www.scdhhs.gov, as a means to communicate with stakeholders, including youth, families, and the provider community about upcoming PCSC changes. Following the public notice process, SCDHHS created and posted a document online containing frequently asked questions. These documents are routinely updated as new questions are received. The website can be accessed from: https://msp.scdhhs.gov/pcsc/site-page/frequently-asked-questions-faq. As part of the public notice process, SCDHHS notified the Medical Care Advisory Committee (MCAC) of the 1915(c) waiver on Feb. 9, 2016. An update was given on May 9, 2017. Notices to all individuals on the SCDHHS email distribution server were sent on May 4, 2017. Copies of these notices are available upon request from SCDHHS.

SCDHHS has notified, in writing, all federally-recognized tribal governments that maintain a primary office and/or majority population within South Carolina of the State's intent to submit this Medicaid 1915(c)waiver request to CMS. This notice was made Feb. 9, 2016, and an update was given on May 9, 2017. Tribal governments received notification of the State's intent to submit a revised version of this request on Feb. 25, 2020. Tribal governments received notification of the waiver amendment action via email on Jan. 26, 2021. The amendment was discussed at a MCAC meeting on August 18, 2020. A copy of the applicable notice is available upon request from SCDHHS.

The proposed waiver amendment was discussed during the virtual SCDHHS MCAC meeting held August 18, 2020, at 10 a.m. from SCDHHS headquarters located at 1801 Main Street, Columbia, S.C. The intent to amend the waiver was also announced during the Nov. 5, 2020 virtual Joint Council on Children and Adolescents meeting. A public comment period was initiated on Jan. 25, 2021. Tribal governments received notification of the waiver amendment action on Jan. 26, 2021. The public notice can be found at this link: https://msp.scdhhs.gov/pcsc/site-page/public-notices. The full waiver amendment can be found at this link:
https://msp.scdhhs.gov/pcsc/sites/default/files/PCSC.WaiverAmendment.FINAL_.pdf.

Additional requests for input were communicated to stakeholders during meetings on Jan. 27, Feb. 3, and Feb. 23, 2021. Hard copies of the public notice and waiver amendment were posted in the State's office lobby. All Healthy Connections Medicaid local eligibility office staff were prepared to respond to public inquiries upon request. No public comments were received for the waiver amendment during the public notice period. Changes requested by the proposed operating entity, Continuum of Care (COC) are documented in the amendment section of the historical PCSC waiver public comments and responses located on the SCDHHS website: www.scdhhs.gov.

J. Notice to Tribal Governments. The state assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. Limited English Proficient Persons. The state assures that it provides meaningful access to waiver services by Limited

English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the state assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

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

Last Name: Alewine

First Name: Margaret

Title: Program Manager II, Community Options, Office of Health Programs

Agency: South Carolina Department of Health and Human Services

Address: P.O. Box 8206

Address 2: 1801 Main Street

City: Columbia

State: **South Carolina**

Zip: 29201

Phone: (803) 898-0047 **Ext:** ☐ **TTY**

Fax: (803) 255-8204

E-mail: margaret.alewine@scdhhs.gov

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

Last Name: Wright

First Name: Greg

Title: Director

Agency: SC Department of Children's Advocacy - Continuum of Care Division

Address:

1205 Pendleton Street, Suite 453A

Address 2:

City: Columbia

State: **South Carolina**

Zip: 29201

Phone: (803) 734-3165 **Ext:** ☐ **TTY**

Fax: (803) 734-4538

E-mail: Greg.Wright@ChildAdvocate.sc.gov

8. Authorizing Signature

This document, together with the attached revisions to the affected components of the waiver, constitutes the state's request to amend its approved waiver under §1915(c) of the Social Security Act. The state affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The state further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The state certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

Signature: Robert Kerr

State Medicaid Director or Designee

Submission Date: Jun 15, 2021

Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.

Last Name: Robert

First Name: Kerr

Title: Director

Agency: South Carolina Department of Health and Human Services

Address: 1801 Main Street

Address 2:

City: Columbia

State: South Carolina

Zip: 29201

Phone: (803) 898-1017 **Ext:** ☐ **TTY**

Fax: (803) 255-8209

E-mail: thomas.phillip@scdhhs.gov

Attachments

Attachment #1: Transition Plan

Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

- ☐ **Replacing an approved waiver with this waiver.**
- ☐ **Combining waivers.**
- ☐ **Splitting one waiver into two waivers.**
- ☐ **Eliminating a service.**
- ☐ **Adding or decreasing an individual cost limit pertaining to eligibility.**
- ☐ **Adding or decreasing limits to a service or a set of services, as specified in Appendix C.**
- ☐ **Reducing the unduplicated count of participants (Factor C).**
- ☐ **Adding new, or decreasing, a limitation on the number of participants served at any point in time.**
- ☐ **Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.**
- ☐ **Making any changes that could result in reduced services to participants.**

Specify the transition plan for the waiver:

Attachment #2: Home and Community-Based Settings Waiver Transition Plan

Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.

To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.

Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.

Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

1. **State Line of Authority for Waiver Operation.** Specify the state line of authority for the operation of the waiver (*select one*):

   ○ **The waiver is operated by the state Medicaid agency.**

   Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program *(select one)*:

   ○ **The Medical Assistance Unit.**

   Specify the unit name:

   (Do not complete item A-2)

   ○ **Another division/unit within the state Medicaid agency that is separate from the Medical Assistance Unit.**

   Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

   (Complete item A-2-a).

   ◉ **The waiver is operated by a separate agency of the state that is not a division/unit of the Medicaid agency.**

   Specify the division/unit name:

   South Carolina Department of Children's Advocacy - Continuum of Care Divsion

   In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *(Complete item A-2-b).*

Appendix A: Waiver Administration and Operation

2. **Oversight of Performance.**

   a. **Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:
   As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.

b. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

SCDHHS and COC entered into a Memorandum of Agreement (MOA) delegating specific operating functions of the waiver to COC. The MOA will be reviewed annually or more frequently if deemed necessary by both parties. COC agrees to perform the following operational or administrative functions:
1. In accordance with Medicaid policy and regulations, COC agrees to make available to beneficiaries, who meet the level of care criteria and whose needs can be addressed through the provision of the PCSC waiver, High Fidelity Wraparound intensive care coordination;
2. Conduct evaluation and re-evaluation of level of care;
3. Monitor provision of service plans and subsequent service plan delivery to ensure compliance with federal standards. Monitoring includes health and welfare safeguards;
4. Establish eligibility for waiver services.
A copy of the executed MOA is available upon request.

The State assesses performance of the operating agency annually with ongoing monitoring of administrative functions in the IT system.

Appendix A: Waiver Administration and Operation

3. Use of Contracted Entities. Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

○ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

◉ **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

4. Role of Local/Regional Non-State Entities. Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

◉ **Not applicable**

○ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:

☐ **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

Specify the nature of these agencies and complete items A-5 and A-6:

☐ **Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Specify the nature of these entities and complete items A-5 and A-6:

Appendix A: Waiver Administration and Operation

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

SCDHHS is responsible for assessing the performance of contracted entities conducting waiver administrative functions.

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

SCDHHS assesses the performance of contracted entities conducting waiver administrative functions on an ongoing basis by meeting at least quarterly, if not more frequently, regarding contract deliverables, implementation barriers, and financial reporting. Vendors submit brief implementation reports at least quarterly to document compliance with contract requirements. PCSC staff continue to demonstrate that the most successful partnerships are engaging, collaborative efforts where problems are identified early and addressed thoughtfully.

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Other State Operating Agency
Participant waiver enrollment	☒	☒
Waiver enrollment managed against approved limits	☒	☒
Waiver expenditures managed against approved levels	☒	☐
Level of care evaluation	☒	☒

Function	Medicaid Agency	Other State Operating Agency
Review of Participant service plans	☒	☒
Prior authorization of waiver services	☒	☒
Utilization management	☒	☒
Qualified provider enrollment	☒	☒
Execution of Medicaid provider agreements	☒	☐
Establishment of a statewide rate methodology	☒	☐
Rules, policies, procedures and information development governing the waiver program	☒	☒
Quality assurance and quality improvement activities	☒	☒

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Administrative Authority

The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

i. Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. *As necessary and applicable, performance measures should focus on:*

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver
- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Policy changes related to the waiver are approved by SCDHHS prior to implementation.
Numerator - the number of waiver policy changes approved by SCDHHS prior to implementation Denominator - the total number of changes implemented

Data Source (Select one):
On-site observations, interviews, monitoring
If 'Other' is selected, specify:

Responsible Party for data	Frequency of data	Sampling Approach*(check*

collection/generation*(check each that applies):*	**collection/generation***(check each that applies):*	*each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Other** Specify:

Performance Measure:
Number and percent of participants enrolled according to date of eligibility. Numerator - Number of participants enrolled based on date of eligibility Denominator - Total number of participants enrolled during the waiver year

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of participants residing in non-traditional settings that meet SCDSS licensing standards as outlined in the approved waiver. Numerator - Number of participants residing in non-traditional settings that meet licensing standards as outlined in the approved waiver Denominator - Total number of participants residing in non-traditional settings

Data Source (Select one):
On-site observations, interviews, monitoring
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☒ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of corrective action plans (CAPs)received from the operating agency within the timeframe outlined in the approved waiver. Numerator – Number of CAPs received from the operating agency within the timeframe outlined in the approved waiver Denominator – Number of CAPs requiring submission from the operating agency within the timeframe outlined in the approved waiver

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

SCDHHS staff conduct performance reviews on providers to ensure that functions are being carried out as required. If concerns are found, SCDHHS notifies the provider and requests a plan of correction. SCDHHS provides additional oversight in areas of concern until the provider has completed a plan of correction and demonstrated appropriate performance.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-

operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-1: Specification of the Waiver Target Group(s)

a. Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the state limits waiver services to one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☐ **Aged or Disabled, or Both - General**					
	☐	**Aged**			☐
	☐	**Disabled (Physical)**			
	☐	**Disabled (Other)**			
☐ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	**Brain Injury**			☐
	☐	**HIV/AIDS**			☐
	☐	**Medically Fragile**			☐
	☐	**Technology Dependent**			☐
☐ **Intellectual Disability or Developmental Disability, or Both**					
	☐	**Autism**			☐
	☐	**Developmental Disability**			☐
	☐	**Intellectual Disability**			☐
☒ **Mental Illness**					
	☐	**Mental Illness**			☐
	☒	**Serious Emotional Disturbance**	0	21	

b. Additional Criteria. The state further specifies its target group(s) as follows:

Youth who have serious emotional disturbance or substance use disorders and who are in or at most risk of out of home placement and are aged 21 or under. Before an applicant is referred for a waiver level of care (LOC) assessment, targeting criteria must be met. Waiver participants must meet institutional LOC. Together, serious emotional disturbance or substance use disorder are both behavioral health diagnoses. The criteria also include youth with a primary diagnosis of serious emotional disturbance and a co-occurring developmental disorder, such as youth with serious emotional disturbance who also have secondary diagnosis of autism spectrum disorder.

Diagnoses include:
DSM-5 (ICD-10) Diagnoses for South Carolina SED Population
Schizophrenia Spectrum and Other Psychotic Disorders
Bipolar and Related Disorders
Depressive Disorders
Anxiety Disorders
Obsessive Compulsive and Related Disorders
Trauma and Stressor Related Disorders
Dissociative Disorders
Feeding and Eating Disorders
Elimination Disorders
Sleep Wake Disorders
Gender Dysphoria
Disruptive, Impulse Control, and Conduct Disorders
Personality Disorders
Paraphilic Disorders
Neurodevelopmental Disorders
Nonpsychotic Mental Disorder, Unspecified

DSM-5 (ICD-10) Diagnoses for South Carolina's SUD Population and Co-Occurring SED/SUD Population
Substance-Related and Addictive Disorders
Caffeine-Related Disorders
Cannabis-Related Disorders
Hallucinogen Related Disorders
Other Hallucinogen Disorder (Specify the particular hallucinogen)
Phencyclidine Intoxication
Other Hallucinogen Intoxication
Hallucinogen Persisting Perception Disorder
Unspecified Phencyclidine-Related Disorder
Unspecified Hallucinogen-Related Disorder
Inhalant-Related Disorders
Inhalant Use Disorder
Inhalant Intoxication
Unspecified Inhalant-Related Disorder
Opioid-Related Disorders
Opioid Use Disorder
Opioid Intoxication
Without perceptual disturbances
With perceptual disturbances
Opioid Withdrawal
Unspecified Opioid-Related Disorder
Sedative-, Hypnotic-, or Anxiolytic-Related Disorders
Sedative, Hypnotic, or Anxiolytic Use Disorder
Sedative, Hypnotic, or Anxiolytic Intoxication
Sedative, Hypnotic, or Anxiolytic Withdrawal
Unspecified Sedative-, Hypnotic-, or Anxiolytic Disorder
Stimulant-Related Disorders
Stimulant Use Disorder
Stimulant Intoxication
Stimulant Withdrawal

Unspecified Stimulate Related Disorder
Tobacco-Related Disorders
Tobacco Use Disorders
Other (or Unknown) Substance-Related Disorders
Other (or Unknown) Substance Use Disorder
Other (or Unknown) Substance Use Intoxication
Other (or Unknown) Substance Withdrawal
Unspecified Other or Unknown Substance-Related Disorder
Non-Substance-Related Disorders
Gambling Disorder

DSM-5 (ICD-10) Diagnoses for South Carolina - Other Populations
Abuse and Neglect - Child Maltreatment and Neglect Problems
Child Physical Abuse Confirmed
Child Physical Abuse, Suspected
Other Circumstances related to Child Physical Abuse
Child Sexual Abuse Confirmed
Child Sexual Abuse, Suspected
Other Circumstances related to Child Sexual Abuse
Child Neglect, Confirmed
Child Neglect, Suspected
Other Circumstances related to Child Neglect
Child Psychological Abuse, Confirmed
Child Psychological Abuse, Suspected
Other Circumstances related to Child Psychological Abuse

c. Transition of Individuals Affected by Maximum Age Limitation. When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit *(select one):*

○ **Not applicable. There is no maximum age limit**

◉ **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

Six months prior to the participant reaching age 21, the family is given information regarding the transition planning procedures. A High Fidelity Wraparound facilitator is available to meet with the family to discuss the transition process. SCDHHS provides families with information about other state plan services that might be available to participant upon their discharge. SCDHHS and the participant and family team works with the family to ensure that they are aware of and have access to available services that they can utilize to support them upon discharge from the waiver. SCDHHS staff and the Wraparound Facilitator are responsible for tracking when a waiver participant reaches age 21 and the wraparound facilitator is responsible for coordinating a formal transition team meeting.

Three months prior to the participant "aging out" of the PCSC waiver, the family's wraparound facilitator schedules a participant and family team meeting to develop a formal transition plan with action steps and transitional services. The participant's person-centered plan must be signed by the wraparound facilitator as well as the family or participant. The family or participant signature designates that they approve of the transition plan. After the meeting, appropriate referrals are made by the wraparound facilitator to ensure appropriate supports and services are put in place upon the participant aging out of the waiver. The participant’s transition plan specifies transitional services being pursued on their behalf and contains evidence that appropriate referrals or coordination have been initiated.

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

a. Individual Cost Limit. The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual *(select one)*. Please note that a state may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

- (●) **No Cost Limit.** The state does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*
- ( ) **Cost Limit in Excess of Institutional Costs.** The state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the state. *Complete Items B-2-b and B-2-c.*

  The limit specified by the state is *(select one)*

  - ( ) **A level higher than 100% of the institutional average.**

    Specify the percentage: [ ]

  - ( ) **Other**

    Specify:

    [ ]

- ( ) **Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*
- ( ) **Cost Limit Lower Than Institutional Costs.** The state refuses entrance to the waiver to any otherwise qualified individual when the state reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the state that is less than the cost of a level of care specified for the waiver.

  Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.

  [ ]

  The cost limit specified by the state is *(select one)*:

  - ( ) **The following dollar amount:**

    Specify dollar amount: [ ]

    The dollar amount *(select one)*

    - ( ) **Is adjusted each year that the waiver is in effect by applying the following formula:**

      Specify the formula:

      [ ]

    - ( ) **May be adjusted during the period the waiver is in effect. The state will submit a waiver**

amendment to CMS to adjust the dollar amount.

○ **The following percentage that is less than 100% of the institutional average:**

Specify percent:

○ **Other:**

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

Answers provided in Appendix B-2-a indicate that you do not need to complete this section.

b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

c. Participant Safeguards. When the state specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the state has established the following safeguards to avoid an adverse impact on the participant *(check each that applies)*:

☐ **The participant is referred to another waiver that can accommodate the individual's needs.**

☐ **Additional services in excess of the individual cost limit may be authorized.**

Specify the procedures for authorizing additional services, including the amount that may be authorized:

☐ **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

a. Unduplicated Number of Participants. The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The state will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	240
Year 2	290
Year 3	360
Year 4	420
Year 5	480

b. Limitation on the Number of Participants Served at Any Point in Time. Consistent with the unduplicated number of participants specified in Item B-3-a, the state may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the state limits the number of participants in this way: *(select one)* :

○ **The state does not limit the number of participants that it serves at any point in time during a waiver year.**

◉ **The state limits the number of participants that it serves at any point in time during a waiver year.**

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	200
Year 2	250
Year 3	300
Year 4	350
Year 5	400

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

c. Reserved Waiver Capacity. The state may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:

○ **Not applicable. The state does not reserve capacity.**

◉ **The state reserves capacity for the following purpose(s).**

Purpose(s) the state reserves capacity for:

Purposes	
Institutional Diversion or Step-down	

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup):*

Institutional Diversion or Step-down

Purpose *(describe):*

Leaving institutions or being diverted from institutions.

Describe how the amount of reserved capacity was determined:

The number of youth leaving institutions and needing support to remain in community.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	5
Year 2	5
Year 3	5
Year 4	5
Year 5	5

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (3 of 4)

d. Scheduled Phase-In or Phase-Out. Within a waiver year, the state may make the number of participants who are served subject to a phase-in or phase-out schedule *(select one)*:

- (●) **The waiver is not subject to a phase-in or a phase-out schedule.**
- ( ) **The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

e. Allocation of Waiver Capacity.

Select one:

- (●) **Waiver capacity is allocated/managed on a statewide basis.**
- ( ) **Waiver capacity is allocated to local/regional non-state entities.**

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

f. Selection of Entrants to the Waiver. Specify the policies that apply to the selection of individuals for entrance to the waiver:

Entry to the waiver is offered to individuals based on the date of their application for the waiver (first come first served basis). COC with oversight from SCDHHS maintains the waiver access to ensure equitable distribution of waiver openings in all geographic areas covered by the waiver and to ensure that no one region maintains its own waiting list.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a. **1. State Classification.** The state is a *(select one)*:

- (●) **§1634 State**
- ( ) **SSI Criteria State**
- ( ) **209(b) State**

2. Miller Trust State.

Indicate whether the state is a Miller Trust State *(select one)*:

- ( ) **No**
- (●) **Yes**

b. Medicaid Eligibility Groups Served in the Waiver. Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the state plan. The state applies all applicable federal financial participation limits under the plan. *Check all that apply*:

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)

- [ ] **Low income families with children as provided in §1931 of the Act**
- [x] **SSI recipients**
- [ ] **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- [x] **Optional state supplement recipients**
- [x] **Optional categorically needy aged and/or disabled individuals who have income at:**

  Select one:

  - (●) **100% of the Federal poverty level (FPL)**
  - ( ) **% of FPL, which is lower than 100% of FPL.**

    Specify percentage: [ ]

- [ ] **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**
- [ ] **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**
- [ ] **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**
- [x] **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**
- [ ] **Medically needy in 209(b) States (42 CFR §435.330)**
- [ ] **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**

☒ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)**

Specify:

Parents and other caretaker relatives: 42 CFR 435.110
Transitional Medical Assistance – extended Medicaid due to earnings:
Section 1925 of the Act
Extended Medicaid due to spousal support collections: 42 CFR 435.115
Pregnant women: 42 CFR 435.116
Children under age 19: 42 CFR 435.118
Deemed newborns: 42 CFR 435.117
IV-E adoption assistance and foster care children: 42 CFR 435.145
Former foster care group: Section 1902(a)(10)(A)(i)(IX) of the Act
Parents and other caretaker relatives: Section 1902(a)(10)(A)(ii)(I) of the Act
Optional targeted low-income children (M-CHIP): 42 CFR 435.229
Optional reasonable classifications of children: 42 CFR 435.222
Non-IV-E state subsidized adoption children: 42 CFR 435.227
Independent foster care adolescents: Section 1902(a)(10)(A)(ii)(XVII) of the Act
Aged, blind and disabled individuals covered under 42 CFR 435.230. Individuals receiving SSI (42 CFR 435.120) and individuals in states using more restrictive requirements for Medicaid than the SSI requirements (42 CFR 435.121).

Special home and community-based waiver group under 42 CFR §435.217) *Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed*

○ **No. The state does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.** *Appendix B-5 is not submitted.*

◉ **Yes. The state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.**

Select one and complete Appendix B-5.

○ **All individuals in the special home and community-based waiver group under 42 CFR §435.217**

◉ **Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217**

Check each that applies:

☒ **A special income level equal to:**

Select one:

◉ **300% of the SSI Federal Benefit Rate (FBR)**

○ **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage: [ ]

○ **A dollar amount which is lower than 300%.**

Specify dollar amount: [ ]

☐ **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**

☐ **Medically needy without spend down in states which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**

☐ **Medically needy without spend down in 209(b) States (42 CFR §435.330)**

☐ **Aged and disabled individuals who have income at:**

Select one:

○ **100% of FPL**

○ **% of FPL, which is lower than 100%.**

Specify percentage amount:

☐ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 7)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group.

a. Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217:

Note: For the period beginning January 1, 2014 and extending through September 30, 2019 (or other date as required by law), the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

☒ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses *spousal* post-eligibility rules under §1924 of the Act.**
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law).

Note: The following selections apply for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law) (select one).

◉ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

In the case of a participant with a community spouse, the state elects to (*select one*):

◉ **Use spousal post-eligibility rules under §1924 of the Act.**
(Complete Item B-5-b (SSI State) and Item B-5-d)

○ **Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

○ **Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The state uses regular post-eligibility rules for individuals with a community spouse.**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

b. Regular Post-Eligibility Treatment of Income: SSI State.

The state uses the post-eligibility rules at 42 CFR 435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

◉ **The following standard included under the state plan**

Select one:

○ **SSI standard**
○ **Optional state supplement standard**
○ **Medically needy income standard**
◉ **The special income level for institutionalized persons**

(*select one*):

◉ **300% of the SSI Federal Benefit Rate (FBR)**
○ **A percentage of the FBR, which is less than 300%**

Specify the percentage:

○ **A dollar amount which is less than 300%.**

Specify dollar amount:

○ **A percentage of the Federal poverty level**

Specify percentage:

○ **Other standard included under the state Plan**

Specify:

○ **The following dollar amount**

Specify dollar amount: If this amount changes, this item will be revised.

○ **The following formula is used to determine the needs allowance:**

Specify:

○ **Other**

Specify:

ii. Allowance for the spouse only (*select one*):

- (●) **Not Applicable**
- ( ) **The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:**

Specify:

Specify the amount of the allowance (*select one*):

- ( ) **SSI standard**
- ( ) **Optional state supplement standard**
- ( ) **Medically needy income standard**
- ( ) **The following dollar amount:**

Specify dollar amount: If this amount changes, this item will be revised.

- ( ) **The amount is determined using the following formula:**

Specify:

iii. Allowance for the family (*select one*):

- ( ) **Not Applicable (see instructions)**
- (●) **AFDC need standard**
- ( ) **Medically needy income standard**
- ( ) **The following dollar amount:**

Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the state's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

- ( ) **The amount is determined using the following formula:**

Specify:

- ( ) **Other**

Specify:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

- ○ **Not Applicable (see instructions)***Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*
- ○ **The state does not establish reasonable limits.**
- ◉ **The state establishes the following reasonable limits**

Specify:

1. Prescription drugs above the four (4) prescriptions per month limit, not to exceed $54 per additional prescription per month.

2. Eyeglasses not otherwise covered by the Medicaid program, not to exceed a total of $108 per occurrence for lenses, frames and dispensing fee. The necessity for eyeglasses must be certified by a licensed practitioner of optometry or ophthalmology.

3. Dentures - A one-time expense not to exceed $651.00 per plate or $1320.00 for one full pair of new dentures. The necessity for dentures must be certified by a licensed dental practitioner. An expense for more than one pair of dentures must be approved by the staff of the South Carolina Department of Health and Human Services (SCDHHS).

4. Denture repair which is justified as necessary by a licensed dental practitioner, not to exceed $77.00 per occurrence.

5. Physician and other medical practitioner visits above the 12 visit limit per fiscal year, not to exceed $69 per visit.

6. Hearing Aids - A one time expense, not to exceed $1000.00 for one or $2000.00 for both. The necessity for a hearing aid must be certified by a licensed practitioner. An expense for more than one hearing aid must be prior approved by staff of SCDHHS.

7. The deduction for medical and remedial care expenses that were incurred as the result of imposition of a transfer of assets penalty period is limited to zero.

8. Reasonable and necessary medical and remedial care expenses not covered by Medicaid incurred in the three months prior to the month of application are allowable deductions. Expenses incurred prior to this three month period are not allowable deductions.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

c. Regular Post-Eligibility Treatment of Income: 209(B) State.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The state uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

i. Allowance for the personal needs of the waiver participant

(*select one*):

- ○ **SSI standard**
- ○ **Optional state supplement standard**
- ○ **Medically needy income standard**
- ◉ **The special income level for institutionalized persons**
- ○ **A percentage of the Federal poverty level**

  Specify percentage:
- ○ **The following dollar amount:**

  Specify dollar amount: If this amount changes, this item will be revised
- ○ **The following formula is used to determine the needs allowance:**

  Specify formula:
- ○ **Other**

  Specify:

ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.

Select one:

- ◉ **Allowance is the same**
- ○ **Allowance is different.**

  Explanation of difference:

iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:

a. Health insurance premiums, deductibles and co-insurance charges

b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

- ○ **Not Applicable (see instructions)***Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*
- ○ **The state does not establish reasonable limits.**
- ◉ **The state uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (5 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

e. Regular Post-Eligibility Treatment of Income: §1634 State - 2014 through 2018.

Answers provided in Appendix B-5-a indicate the selections in B-5-b also apply to B-5-e.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (6 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

f. Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (7 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018.

The state uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

Answers provided in Appendix B-5-a indicate the selections in B-5-d also apply to B-5-g.

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the state provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

a. Reasonable Indication of Need for Services. In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the state's policies concerning the reasonable indication of the need for services:

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

ii. Frequency of services. The state requires (select one):

- (●) **The provision of waiver services at least monthly**
- ( ) **Monthly monitoring of the individual when services are furnished on a less than monthly basis**

If the state also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

b. Responsibility for Performing Evaluations and Reevaluations. Level of care evaluations and reevaluations are performed (*select one*):

- ( ) **Directly by the Medicaid agency**
- (●) **By the operating agency specified in Appendix A**
- ( ) **By a government agency under contract with the Medicaid agency.**

Specify the entity:

- ( ) **Other**

Specify:

c. Qualifications of Individuals Performing Initial Evaluation: Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

Level of care (LOC) is determined using the Child and Adolescent Service Intensity Instrument (CASII). Developed by the American Academy of Child and Adolescent Psychiatry, the instrument is a standardized assessment tool that provides a determination of the appropriate level of service intensity needed by an participant and family members. Only those individuals verified as having been trained in the administration and scoring of the CASII instrument are permitted to conduct LOC assessments. COC staff have been trained to administer and score the CASII. This training is separate and distinct from Wraparound training and certification.

COC Intake Coordinators, Wrap Facilitators and Wrap Team Leads performing LOC assessments must hold a Bachelor's or Master's degree in a human service of social sciences related field. COC Wrap Supervisors and Regional Program Directors performing and scoring LOC assessments must hold a Master's Degree and be a Licensed Practitioner of the Healing Arts. All COC staff performing or scoring LOC assessments must pass a South Carolina criminal history background check, child abuse and neglect screen, motor vehicle screen, and excluded provider screen.

CASII assessments are forwarded to SCDHHS for review.

d. Level of Care Criteria. Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the state's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

LOC is determined using the Child and Adolescent Service Intensity Instrument (CASII).
The CASII is completed initially when the participant is referred for services and annually thereafter.

The CASII is completed face-to-face based on an interview with the participant (and parent(s) when possible) and additional supporting information. The CASII takes into consideration child development and the importance of the parents and the community in supporting the participant. It is used to determine the intensity of needed services. The CASII has six dimensions: Risk of Harm, Functional Status, Co-Morbidity, Recovery Environment, Resiliency and Treatment History, and Acceptance and Engagement. Each dimension has a five-point rating scale. For each of the five possible ratings within each dimension, a set of criteria is clearly defined. Only one criterion needs to be met for that rating to be selected.

Reevaluation: In addition to input from the participant and family, the evaluator will consider information gathered from supporting documentation in the participant's record. Every 12 months, or more frequently if necessary due to a significant change in the participant's condition or needs, a participant's LOC shall be reevaluated for continued participation in the program. A participant is considered to meet the hospital facility LOC if the participant would be in need of a hospital placement but for the continued receipt of waiver services. The reevaluation also takes into account clinical evidence of therapeutic clinical goals that must be met before the individual can transition to a less intensive LOC and clinical evidence of symptom improvement.

e. Level of Care Instrument(s). Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care *(select one)*:

- ○ **The same instrument is used in determining the level of care for the waiver and for institutional care under the state Plan.**
- ◉ **A different instrument is used to determine the level of care for the waiver than for institutional care under the state plan.**

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

The State has compared the CASII assessment tool to the hospital certification requirements and found that all hospital certification requested information and values are included in the CASII. The CASII has demonstrated strong reliability across users and validity relative to other assessments as well as in predicting treatment and LOC needs. The CASII LOC determination is set at the same levels as the South Carolina hospital levels of care. This results in determinations that are fully comparable to the SCDHHS hospital certification LOC criteria.

f. Process for Level of Care Evaluation/Reevaluation: Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

There are two areas of eligibility a participant must meet: Clinical (also called Functional) and Financial (also called Medicaid).

Clinical Evaluation. A wraparound facilitator credentialed to administer the Child and Adolescent Service Intensity Instrument (CASII) must determine that the youth meets the targeting criteria of the waiver and functional criteria. Key features of clinical eligibility include:

- Age - A participant must be aged 21 or younger.
- Diagnosis - A primary mental health diagnosis meeting the targeting criteria in Section B-1 above must be present.
- Functional Assessment - All participant's in the waiver must meet minimum scores for the hospital LOC as determined by the CASII.

The State intends to use the CASII to determine eligibility for applicants who are currently receiving High Fidelity Wraparound through the Continuum of Care (COC) within the South Carolina Department of Children's Advocacy at the implementation of the waiver. Due to the receipt of High Fidelity Wraparound services, some applicants may not meet the CASII level of care threshold for the waiver. However, the State believes the needs of this applicant group would be met per the CASII assessment if it were not for High Fidelity Wraparound services.

Before an LOC is performed, COC, as the operating entity, will perform a brief screening. The brief screening tool determines if the participant meets the targeting criteria for a waiver LOC assessment. COC will verify the information obtained during the brief screen, and then schedule and conduct the LOC assessment. SCDHHS is notified when the LOC assessment is complete. If the applicant meets the LOC threshold, a provisional plan of care (crisis plan) or person-centered plan has been developed, and financial eligibility has been determined, SCDHHS staff will enroll the applicant in the waiver. SCDHHS makes the final waiver enrollment determination. LOC referrals, LOC assessment scores, clinical recommendations, and plans of care are recorded and monitored in the electronic case management system.

Case Management Choice and Release of Information Form - Documentation that the parents or caregivers of the participant chose to participate in the waiver rather than seek hospitalization or nursing facility placement.

Financial Eligibility - If a participant is not already eligible for Medicaid, a financial eligibility determination for Medicaid is completed prior to the LOC determination. A financial re-determination occurs annually.

Annual Reevaluation - The need for HCBS waiver services is reevaluated at a minimum annually. The format for reevaluating the LOC is guided by the clinical evaluations of the licensed professional, the progress towards goals and objectives, and the CASII which is completed annually. The reevaluation process does differ from the initial evaluation. In the initial evaluation, the evaluator conducts the standard assessment (CASII), a clinical narrative, and clinical indication that the participant is determined to need State psychiatric hospitalization placement in absence of HCBS waiver services. The reevaluation contains a clinical narrative and focuses on whether the participant continues to need a psychiatric hospitalization LOC.

Notice of Action - When a participant is found ineligible during the initial evaluation or the annual reevaluation, their family receives a Notice of Action advising them of the status of clinical eligibility.

All clinical eligibility documentation including the initial evaluation, annual reevaluation and the notice of action are to be maintained in the participant’s clinical record in the case management system.

All LOC decisions are reviewed by SCDHHS waiver staff for consistency with State guidelines.

g. Reevaluation Schedule. Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule *(select one)*:

- ○ **Every three months**
- ○ **Every six months**
- ◉ **Every twelve months**
- ○ **Other schedule**

  Specify the other schedule:

h. Qualifications of Individuals Who Perform Reevaluations. Specify the qualifications of individuals who perform reevaluations *(select one)*:

- (●) **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
- ( ) **The qualifications are different.**
  Specify the qualifications:

i. Procedures to Ensure Timely Reevaluations. Per 42 CFR §441.303(c)(4), specify the procedures that the state employs to ensure timely reevaluations of level of care *(specify):*

SCDHHS and the waiver participant's wraparound facilitator both monitor the annual reevaluation date through an electronic tracking system to ensure that the LOC is completed every twelve months or if there is a significant change in the participant's condition or needs.

j. Maintenance of Evaluation/Reevaluation Records. Per 42 CFR §441.303(c)(3), the state assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

COC uploads original documents into the SCDHHS-owned IT system. SCDHHS has the ability to access all documents and associated data.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Level of Care Assurance/Sub-assurances

The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.

i. Sub-Assurances:

a. ***Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of new waiver applicants who had an LOC determination indicating a need for inpatient hospital LOC prior to waiver enrollment and receipt of services. Numerator - number of new applicants who received an LOC assessment indicating inpatient hospital LOC prior to waiver enrollment and receipt of services Denominator - total number of new waiver enrollees during the waiver year

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

c. ***Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of participants with initial level of care determinations reviewed

that were completed using the process required by the approved waiver Numerator - number of participants with initial level of care determinations reviewed that were completed using the required process Denominator - total number of new enrollees during the waiver year

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of applicants referred for LOC assessment with a brief screen indicating applicant could meet inpatient hospital LOC. Numerator - number of new applicants referred for LOC assessment with a brief screen indicating applicant could meet inpatient hospital LOC Denominator - total number of applicants with a completed brief screen during the waiver year

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on

the methods used by the state to document these items.

When issues are discovered by SCDHHS through formal quality review processes the responsible party is notified by SCDHHS staff. SCDHHS staff identifies the problem, makes the responsible party aware of the problem and ensures that they have appropriate information to correct the problem. SCDHHS staff formally issue a statement of deficiency requiring a corrective action plan (CAP). If SCDHHS deems the problem/issue/concern to cause imminent danger to the waiver operations or youth, SCDHHS notifies the responsible party and they are restricted from conducting waiver related supports and services until the issue is resolved and SCDHHS accepts the CAP. The CAP response must be submitted within 30 days of the receipt of the CAP by the responsibility party. The corrective action plan both addresses immediate problems and identifies how the problems can be avoided in the future. Documentation is submitted to SCDHHS to support corrective actions as proof that the issue has been addressed. SCDHHS reviews corrective action plans to ensure that they address the underlying issues/concerns. SCDHHS reviews past quality review findings at future reviews to ensure that the issues have not continued. Failure to submit and implement a corrective action plan may result in the provider being excluded from the waiver.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

Freedom of Choice. *As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:*

i. informed of any feasible alternatives under the waiver; and
ii. given the choice of either institutional or home and community-based services.

a. Procedures. Specify the state's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

As part of the enrollment process, the wraparound facilitator discusses with the family all aspects of the waiver. Staff answer questions and address any concerns. During this conversation, staff discusses Freedom of Choice. Regardless of which option the family chooses – institutional or home and community-based services – they are required to sign a Freedom of Choice Form, indicating their selection. The family is assured that they will not be penalized in any way or denied services due to their choice.

b. Maintenance of Forms. Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

The original documents are housed with the wraparound facilitator files.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the state uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

The waiver intake process ensures that the participant language needs are assessed. Where appropriate, interpreter services are provided. In addition, prior to enrollment approval, all providers of waiver services must have a protocol system in place that allows access to services by persons with limited English proficiency. Designated staff within the provider agencies are responsible for assuring compliance and access to services by persons with limited English proficiency.

SCDHHS is responsible for monitoring the compliance process. The provider agency can request assistance from SCDHHS. SCDHHS assists the provider agency with identifying resources when/if necessary. SCDHHS requires each provider agency to be in compliance with Title VI. The State establishes a grievance procedure as outlined in Appendix F to assure that everyone is given a fair and timely review of all complaints alleging discrimination. Prior to enrollment approval, all providers must agree, in writing, to the "Assurance of Compliance" statement.

The SCDHHS waiver staff is responsible for maintaining records documenting the complaints filed and actions that are taken to bring resolution to the complaint(s). These records are reviewed by SCDHHS, as part of the overall quality assurance process. The SCDHHS waiver staff is responsible for notifying SCDHHS quality assurance process of any discrimination complaints that have been filed.

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

a. Waiver Services Summary. *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

Service Type	Service		
Statutory Service	**High Fidelity Wraparound**		
Statutory Service	**Respite**		
Other Service	**Individual Directed Goods and Services**		

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Case Management

Alternate Service Title (if any):

High Fidelity Wraparound

HCBS Taxonomy:

Category 1:	Sub-Category 1:
01 Case Management	01010 case management
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

High Fidelity Wraparound 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 High Fidelity Wraparound (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 will contract solely with the COC to perform the HFW service. Originally established in 1983 by the South Carolina General Assembly, the COC for Emotionally Disturbed Children now the COC, is a South Carolina state program that serves children with serious emotional or behavioral health diagnoses whose families need help keeping them in their home, school or community. The COC implemented the wraparound model in 2014 and is the only provider of HFW in the state of South Carolina.

The COC will receive FFP to perform the HFW intensive care coordination service.

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

Wraparound facilitation may not be provided at the same time as targeted case management and cannot duplicate any Medicaid State Plan Service. All 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.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Care Management Entity (CME)

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: High Fidelity Wraparound

Provider Category:

Agency

Provider Type:

Care Management Entity (CME)

Provider Qualifications

License *(specify):*

Certificate *(specify):*

The wraparound facilitator, wraparound team lead, or wraparound coach/supervisor receives wraparound implementation support from the National Wraparound Implementation Center (NWIC).The CME must meet the standards of High Fidelity Wraparound and demonstrate continued use of evidence-based wraparound standards as approved by SCDHHS through ongoing participation in wraparound fidelity monitoring.

Other Standard *(specify):*

Comply with all SCDHHS standards, including regulations, contract requirements, policies, and procedures relating to provider qualifications and enrollment including state certification requirements for wraparound coach/supervisors.
Each child and family team includes a wraparound facilitator and a credentialed individual meeting the requirements of a Licensed Practitioner of the Healing Arts (LPHA) or employed by a public entity. All members of the child and family team must demonstrate on-going use of evidence-based wraparound standards through wraparound fidelity monitoring. The CAFAS is performed by professionals meeting the requirements outlined by the High Fidelity Wraparound agency and is available to SCDHHS for review.

The child and family team is a multi-disciplinary team trained in High Fidelity Wraparound including: a wraparound facilitator, participant, family, providers, and other persons that the participant and family choose to participate. Decisions on the plan of care are supervised by credentialed individuals meeting the requirements of a Licensed Practitioner of the Healing Arts (LPHA) or individual employed by a public entity.

Wraparound Facilitator
The wraparound facilitator must meet the following requirements:
- A bachelor's degree in a human services or social sciences related field.
- One year of experience with children with serious emotional or behavioral health challenges.
- Completion of the required training for evidence-based, High Fidelity Wraparound process for Wraparound Facilitators.
- Pass a South Carolina criminal history background check, child abuse and neglect screen, motor vehicle screens, and excluded provider screen.
- Bilingual applicants and applicants with one year of experience with children with serious emotional or behavioral health challenges are encouraged to apply.

Wraparound Team Lead
The wraparound team Lead must meet the following minimum requirements:
- Must have professional experience in human services or social services program.
- A bachelor’s degree in a human service or social sciences related field.
- At least 3 years of experience with children with serious emotional and behavioral health challenges.
- Experience in provision of High Fidelity Wraparound and maintain agency standards as a regional mentor.
- Completion of the required training for evidence-based, High Fidelity Wraparound process for wraparound facilitators.
- Must also have experience in provision of High Fidelity Wraparound and maintain agency standards as a regional mentor
- Pass a South Carolina criminal history background check, child abuse and neglect screen, motor vehicle screens, and excluded provider screen.
- Bilingual applicants are encouraged to apply.

Wraparound Coach/Supervisor - Requirements include the following:
- Professional experience in human services or social services programs, a master's degree in a human services or social sciences related field
- Must have two years of case management experience and experience with children with complex emotional or behavioral health challenges.
- Requires a minimum of one year of supervisory experience. Must be licensed or have recently applied for licensure as a LMSW, LPC, LISW-CP, LISW-AP, or LMFT.
- Completion of the required training and State credentialing process for wraparound facilitator supervisors.
- If the coach or supervisor also functions, in part, as a wraparound facilitator, they must also meet the requirements for a wraparound facilitator described above.
- The wraparound facilitator supervisor must provide regular supervision to wraparound facilitation service delivery staff, including completion of all supervisor requirements for wraparound fidelity monitoring.
- The wraparound facilitator Supervisor must have good interpersonal skills for supporting development in others. The supervisor should have a broad base of experience and possess a diverse view of what families need to live better lives. The supervisor must collaborate closely with other

supervisors in other child-serving agencies in the community. A wraparound supervisor should demonstrate skills that support engaging people from different cultures, ages and backgrounds. A preferred supervisor characteristic is an understanding of, and experience with, different systems, including schools, behavioral health, child welfare, juvenile justice, health and others. The Wraparound Facilitator Supervisor must oversee the work of the wraparound facilitation service delivery staff on an ongoing basis.
Licensed Practitioner of the Healing Arts or individual credentialed to provide the assessments employed by a public agency
Each CME must have a Licensed Practitioner of the Healing Arts providing clinical assessments.
• Must be licensed as a LMSW, LPC, LISW-CP, LISW-AP, or LMFT. Psychiatrist and psychologists are also eligible to fulfill this position or credentialed individual employed by a public entity.
• Completion of the required training for evidence-based, High Fidelity Wraparound process for wraparound facilitators.
• Pass a South Carolina criminal history background check, child abuse and neglect screen, motor vehicle screens, and excluded provider screen.
The Care Management Entity must ensure on-going training of all child and family team members either through contract with national bodies or by employing nationally certified trainers. The Care Management Entity must ensure that all child and family team members adhere to wraparound principles and to the HCBS requirements found at 42 CFR 441.301(c) regulation.

Verification of Provider Qualifications

Entity Responsible for Verification:

SCDHHS or its designee

Frequency of Verification:

Initially and annually thereafter (or more frequently based on service monitoring concerns)

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
09 Caregiver Support	09012 respite, in-home
Category 2:	**Sub-Category 2:**

09 Caregiver Support	09011 respite, out-of-home

Category 3: **Sub-Category 3:**

Service Definition *(Scope):*

Category 4: **Sub-Category 4:**

Respite care includes services provided on a short-term, planned or emergency basis, and offers relief to a beneficiary's unpaid caregiver who is unable to provide services to the participant. This service will be provided to meet the participant needs, as per the person-centered plan. Beneficiaries are encouraged to receive respite in the most integrated and cost-effective settings.
Respite services may also include camp funding for summer camp that provides the needed safeguarding services and supports to achieve the person's valued outcomes, as per the person-centered plan. Camps can either be focused on supporting youth with disabilities or camps that are available to the general public.

Services must be delivered in a manner that supports the beneficiary's communication needs including, but not limited to, age appropriate communication, translation services for beneficiaries that are of limited-English proficiency or who have other communication needs requiring translation, assistance with the provider's understanding, and use of communication devices used by the beneficiary. If the beneficiary is to receive respite on an ongoing basis, the care manager will monitor on a quarterly basis. The respite service may also be used to offer relief to a beneficiary's unpaid or principle caregiver who normally provides care.

Respite may be provided in an emergency to prevent hospitalization. Respite is a face-to-face service.

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

No longer than one week per episode, not more than 21 days per year. Stays of greater than 72 hours require prior authorization. Youth requiring crisis respite for longer periods may be evaluated on an individual basis.

Respite services may not be billed at the same time as personal care services.

In settings where permissible and during respite hours in the youth's home, medication may be administered by the respite worker. Medications, including controlled substances, medical supplies, and those items necessary for first aid shall be properly managed in accordance with State, Federal, and local laws and regulations. Such management shall address securing, storing, and administering medications, medical supplies, first aid supplies, and biologicals, their disposal when discontinued or expired, and their disposition at discharge of a participant.

SCDHHS may authorize services above these limits on a case-by-case basis when:
o No other options are available, including respite through informal supports; and
o The absence of respite presents a significant health and welfare risk to the youth.
• Respite provided in a certified residential care facility, substance use disorder residential facility or public or private child service entity shall not replace or relocate a youth's primary residence. Room and board in residential group home or substance use disorder residential facility may be paid for by Medicaid for respite service only. In overnight settings of greater than four residents, between the hours of 7 am to 8 pm there shall be a minimum of one staff person on site for every five youth. Between the hours of 8 pm to 7 am there shall be a minimum of one staff person for every seven youth. At least one staff member must provide 24-hour awake supervision. The term "24-hour awake supervision" means that, during sleeping hours, a staff member is located in a position which allows him or her to observe any movement into or out of a youth's bedroom. On call staff must be available for emergencies and immediately accessible. The director or a designee shall be available at all times by cell phone.
Overnight settings offer a supportive home-like environment with a maximum preferred capacity not to exceed 10 residents, preferably in single rooms.
• Must be building and health and safety code compliant.
• Staffed and open 24 hours a day, seven days a week when a resident is present.
• Youth should be allowed to leave and return as needed, maintaining employment and other daily activities when possible.
To the greatest extent possible, youth are encouraged to maintain contact with significant others, including family members, friends, and spouses. To facilitate this contact, youth may have visitors at any time that is convenient and practical for the resident as well as the operation's overnight setting.

EXCLUSIONS:
• Diagnosis of dementia, organic brain disorder or traumatic brain injury
• Symptoms indicative of active engagement in substance use manifested in aggressive or destructive behavior
• Respite used to replace or relocate an individual's primary residence
• Respite may be not be provided by any person who is a legal guardian or acting in the place of a legal guardian for the youth.
• Respite may not be provided by any spouse or domestic partner of any person who is a legal guardian or acting in the place of a legal guardian for the youth. For example, a stepparent married to the legal guardian of a youth may not provide respite services for that youth.

Medical Necessity Criteria include:
• The service is recommended in collaboration with the youth and included in the person-centered plan; AND
• Emotional or behavioral problems stress the caregiver or youth and put the youth at risk of a more intensive level of care (e.g., strained family relationships; caregiver struggles to meet work responsibilities or lacks time for self-care) OR the primary caregiver has a time limited situation in providing care for the youth (e.g., caregiver is experiencing an acute medical problem); AND
• The absence of the service would present a significant health and welfare risk to the youth (e.g., youth has a seizure disorder or youth needs assistance with medication administration)
• No other means of temporary care exists; AND
• The frequency and intensity of the service aligns with the unique situation of the youth and/or caregiver.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Rehabilitative Behavioral Health Services (RBHS) Provider
Agency	Group Home, if not on an IMD campus
Agency	Home Health Agency
Agency	Supportive Housing Agency
Agency	Public or Private Child Service Entity
Agency	Substance Use Disorder Residential Facility

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Rehabilitative Behavioral Health Services (RBHS) Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

- Comply with all SCDHHS standards, including regulations, contract requirements, policies, and procedures relating to provider qualifications and enrollment.
- New PCSC waiver provider applicants and providers seeking revalidation may be subject to a pre and post site visit.
- Private providers must be accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF), the Council on Accreditation (COA), the Joint Commission in Behavioral Health Services, or Healthcare Facilities Accreditation Program (HFAP).
- Licensed Practitioners of the Healing Arts or medical staff providing supervision to unlicensed staff must be licensed or registered with the State where the business is located.
- RBHS provided by licensed/certified professionals must follow supervision requirements required by SC State Law for each respective profession. RBHS provided by any unlicensed/uncertified professional must be supervised by a master's level clinical professional or licensed practitioner of the healing arts (LPHA). Substance Abuse Professionals who are in the process of becoming credentialed must be supervised by a Certified Substance Abuse Professional or LPHA.
- The applicant must have a business license from the state and/or municipality or county where the service is provided
- Physical or primary business site must be located in the SC Medicaid Service Area (SCMSA)
- Proof of General Liability insurance coverage worth at a minimum of $600,000
- Proof of Worker's Compensation insurance, if five or more full time personnel staff
- Accept the reimbursement rates established by Medicaid.
- Designation by SCDHHS as an RBHS provider entity including compliance with minimum State training requirements.
- RBHS provider entities may provide any component of the services listed and must employ/contract and utilize qualified HCBS providers necessary to maintain youth in the community.

Verification of Provider Qualifications

Entity Responsible for Verification:

SCDHHS or its designee

Frequency of Verification:

Initially and annually thereafter (or more frequently based on service monitoring concerns)

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Group Home, if not on an IMD campus

Provider Qualifications

License *(specify):*

SC Code, Sec. 44-7-260 DHEC Reg. #61-84

Certificate *(specify):*

Other Standard *(specify):*

- Group homes may have no more than 16 beds.
- The agency must maintain a staffing ratio necessary to keep youth safe. An adult staff member must be awake and present at all times in the facility. If cameras are used, the staff must monitor the cameras and be within walking distance of the youth.

Staff must meet the following qualifications and training:
- Availability of a clinician (on call 24/7 for emergencies and staff consultation) with a doctoral or master's degree in clinical or counseling psychology, mental health nursing, clinical social work, vocational/psychiatric rehabilitation or education from an accredited college or university; or a registered nurse with certification in mental health nursing from the American Nurses Association. . The home will also have access to a physician after hours for emergencies.
- Residence Manager - Responsible for the operation of the group home and responsible for the supervision of residents' treatment plans. The qualifications of the Residence Manager must be at least a Bachelor’s degree.
- Residential Service Assistants - A person who has a high school diploma, GED, or CNA.
- The service provider shall comply with criminal background check and drug testing laws. The service provider shall maintain a current personnel policies and procedures manual that sets forth grounds for termination, adequately supports sound resident care and is made readily available to the program's staff in each home. The service provider shall comply with the provisions of such manual.
- Training in risk assessment of dangerousness and interventions aimed at reducing such risk, including training in managing difficult behaviors, in the implementation of de-escalation techniques, and in self-defense techniques to prevent harm from violent behaviors Note: Training in the use of alternatives to seclusion and restraint is required
- A complete course in medications used in the treatment of mental illness including the medications' effects, side effects, and adverse effects (sometimes life threatening) used alone or in combination with other prescription and non-prescription medication and alcoholic or caffeinated beverages;
- Training in the common types of mental illness including signs and symptoms of schizophrenia, mood and personality disorders and indications of deterioration of an individual's mental condition;
- Training in basic first aid, including basic CPR training and fire safety and evacuation procedures;
- An explanation of the rights of youth with psychiatric disabilities in residential care in South Carolina;
- Expectations for confidentiality and ethical behavior towards residents who will reside in the group home;
- Policies and procedures that apply to a group home on both a daily and emergency basis;
- Health care, sanitation, and safe handling of food;
- Orientation to situational counseling, de-escalation and mediation techniques, stress management and social interaction, and
- A plan for the continuing education and development of staff including but not limited to: A protocol and training for all direct care staff on the medication protocols in place for the home (i.e., a nurse or pharmacy sets up the medication and the medications are in daily packages in a locked cabinet. The staff’s role is to make sure the right medications are taken at the right time by observing the youth, but not to “administer” them. A nurse verifies that the medications are taken daily.)
- Training for all direct care staff on any side effects of medications given to house residents, to promote monitoring for symptoms like excessive thirst and other issues that reflect the need for some intervention.
- Training on basic physical health and symptoms to monitor for when a youth is in a residential program.

A service provider need not require training in discrete areas in which the staff person has demonstrated competency through satisfactory job performance or previous experience to the satisfaction of the service provider and SCDHHS.

Verification of Provider Qualifications

Entity Responsible for Verification:

SCDHHS or its designee

Frequency of Verification:

Initially and annually thereafter (or more frequently based on service monitoring concerns)

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

State Business License or 501 (c)(3) status; and State Home Health Agency License per State regulation 61-77.

Licensed staff must adhere to the LLR practice acts for their discipline.
Also guided by S.C. Code Ann. § 44-69-10 through § 44-69-100.

Certificate *(specify):*

Certified to participate under Title XVII (Medicare) by DHEC.

Meet the conditions governing participation as certified by DHEC, and have an approved Certificate of Need (CON) (under DHEC Regulation # 61-15 and SC Code of Law 44-7-110).

Other Standard *(specify):*

- Comply with SCDHHS standards, including regulations, policies and procedures relating to provider qualifications and enrollment.
- Complete and ensure employees complete SCDHHS required training, including training on the youth's person-centered plan and the youth's unique and/or disability specific needs, which may include, but are not limited to, communication, mobility, and behavioral needs.

Individuals employed by providers must:
- Be at least 18 years of age.
- Pass a South Carolina criminal history background check, child abuse and neglect screen, motor vehicle screen, and excluded provider screen.
- In the case of direct care personnel, possess certification through successful completion of training program as required by the SCDHHS.

Verification of Provider Qualifications

Entity Responsible for Verification:

SCDHHS or its designee

Frequency of Verification:

Initially and annually thereafter (or more frequently based on service monitoring concerns)

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Supportive Housing Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The agency must maintain staffing necessary for the health and welfare of the transition age youth. The staff must meet the qualifications and training below.

- Comply with SCDHHS standards, including regulations, policies and procedures relating to provider qualifications and enrollment.
- Complete and ensure employees complete SCDHHS required training, including training on the youth's person-centered plan and the youth's unique and/or disability specific needs, which may include, but is not limited to, communication, mobility, and behavioral needs.
- Organization must be able to document three years of experience in providing services to persons with severe mental illness.
- Comply with and meet all standards as applied through each phase of the standard, annual SCDHHS performed monitoring process.
- Ensure 24-hour access to personnel (via direct employees or a contract) for response to emergency situations that are related to the residential supports or other waiver services.

Employees must:

- Must be at least 18 years old, and have a high school diploma or equivalent.
- Pass a South Carolina criminal history background check, child abuse and neglect screen, motor vehicle screen, and excluded provider screen
- In the case of direct care personnel, possess certification through successful completion of training program as required by the SCDHHS. If providing nursing care, must have qualifications required under State Nurse Practice Act (i.e. RN or LPN).
- Have a valid driver's license if the operation of a vehicle is necessary to provide the service.

All supervised housing staff must complete the training on the following topics:

- CPR
- First Aid
- Introduction to Community-Based Residential Services for Direct Care Staff
- Air and Blood Borne Pathogens
- Non-Physical Crisis De-Escalation, Crisis Management and Debriefing
- Proper Techniques to address Challenging Behavior and Proper Contingency Management
- Principles of Psychiatric Rehabilitation
- Motivational Interviewing for Co-Occurring Disorders
- Basics of Counseling
- Recovery Oriented Service Delivery & Documentation
- What is Peer Support
- Rights and Responsibilities of Individuals receiving Mental Health services
- Cultural Competence and Diversity
- Prevention/Intervention and Recovery/Resiliency Strategies
- Behavioral Health/SUDs and Associated Medical Care and Conditions
- HIPAA and Confidentiality
- Grief, Loss, and Death Notification Procedures
- Applied Suicide Intervention Skills
- Introduction to Human Needs, Values, Guiding Principles, and Effective Teaching Strategies
- Environmental Emergencies: Mitigation, Preparation, and Responding
- Basic Health and Medications
- Advanced Health and Medications
- Nutrition: Food Preparation, Food Storage, Healthy Diet, and Positive Health
- Assessing mobile crisis need

Verification of Provider Qualifications

Entity Responsible for Verification:

SCDHHS or its designee

Frequency of Verification:

Initially and annually thereafter (or more frequently based on service monitoring concerns)

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Public or Private Child Service Entity

Provider Qualifications

License *(specify):*

The provider must have a current South Carolina Department of Social Services (SCDSS) license as a foster care placement institution. In addition, foster homes must be individually licensed by SCDSS as foster care homes.

S.C. Code Ann. §63-11-10 thru 63-11-790 (Supp 2008).

Certificate *(specify):*

Other Standard *(specify):*

• Comply with SCDHHS standards, including regulations, policies and procedures relating to provider qualifications and enrollment
• Complete and ensure employees complete SCDHHS required training, including training on the youth's person-centered plan and the youth's unique and/or disability specific needs, which may include, but is not limited to, communication, mobility, and behavioral needs.
• The provider must be in good standing per State Medicaid regulations. The foster home parents and agency staff must be licensed and/or credentialed per State Medicaid policy.
• All agencies who provide respite services must ensure that all employees participate in required annual training per waiver and State Medicaid policy.

Individuals employed by providers must:
• Be at least 21 years of age.
• Pass a South Carolina criminal history background check, child abuse and neglect screen, motor vehicle screen, and excluded provider screen.
• In the case of direct care personnel, possess certification through successful completion of training program as required by the SCDHHS.

Supervisors of respite staff must meet the following requirements:
• A registered nurse licensed to practice in South Carolina and have at least three years of experience performing clinical or case work activities; or have meet one of the supervisor criteria listed below for in-home.

Respite provided in the youth's home:
Respite staff requirements: An individual who provides respite services, in the participant's home, must be employed through an enrolled respite provider and successfully complete all required training. A respite staff must meet the following requirements:
• Be at least twenty one years of age or older;
• Have knowledge of the needs of children and be capable of meeting the needs of youth in the waiver;
• Be capable of handling an emergency situation;
• Respite staff must take a minimum of fourteen (14) hours of appropriate Respite care training and expected standards of care;
• A minimum of three written letters of reference shall be initially obtained prior to the Respite worker providing respite services to a youth in the youth's home. References should have known the applicants three years prior to the application and, unless specifically requested, should not be related to the applicants.

Supervisors of Respite staff who provide services in the youth's home must ensure that all employees participate in all required training. Supervisors of Respite staff must meet one of the following requirements:
• A master's degree in social work, psychology, counseling, special education, or closely related field
• A baccalaureate degree in social work, psychology, counseling, special education, or in a closely related field and have at least one year of experience performing clinical or case work activities; or
• A baccalaureate degree in an unrelated field of study and at least three years of experience performing clinical or case work activities

Verification of Provider Qualifications

Entity Responsible for Verification:

SCDHHS or its designee

Frequency of Verification:

Initially and annually thereafter (or more frequently based on service monitoring concerns)

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Substance Use Disorder Residential Facility

Provider Qualifications

License *(specify):*

Licensed by SCSCDHEC per 61-93 and S.C. Code Ann. § 44-7-260(A) Licensed staff must adhere to the LLR practice acts for their discipline.

Certificate *(specify):*

Certified by DAODAS

Other Standard *(specify):*

Certified by DAODAS as either a SUD residential or detoxification program and be authorized to provide a set number of licensed beds.

Verification of Provider Qualifications

Entity Responsible for Verification:

SCDHHS or its designee

Frequency of Verification:

Initially and annually (or more frequent based on service monitoring concerns)

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Individual Directed Goods and Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
17 Other Services	17010 goods and services
Category 2:	**Sub-Category 2:**

Category 3: **Sub-Category 3:**

Service Definition *(Scope):*

Category 4: **Sub-Category 4:**

Individual Directed Goods and Services are services, equipment or supplies not otherwise provided through this waiver or through the Medicaid State Plan that address 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.

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

$2,000 lifetime limit per youth. All 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.

Service Delivery Method *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☐ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Private Agency or Private Vendor
Individual	Individuals Hired or Goods Purchased by Participants Who Self-direct

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Individual Directed Goods and Services

Provider Category:

Agency

Provider Type:

Private Agency or Private Vendor

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The state will verify that the agency meets any applicable state regulations for the type of supply or service as described in the approved Individual Plan of Care. If the participant is purchasing direct supports, the agency will ensure that employees meet the following qualifications prior to employment:

- Be at least 18 years of age
- Have high school or equivalent degree
- Comply with all SCDHHS standards including regulations, policies and procedures related to provider qualifications
- Complete SCDHHS required training, including training on the youth's person-centered plan and the youth's unique needs, which may include, but is not limited to, communication, mobility and behavioral needs
- Pass a South Carolina criminal history background check, child abuse and neglect screen, motor vehicle screens, and excluded provider screen
- Have a valid driver's license from South Carolina or a contiguous state if the operation of a vehicle is necessary to provide the service

Verification of Provider Qualifications

Entity Responsible for Verification:

SCDHHS or its designee

Frequency of Verification:

Initially and annually thereafter (or more frequently based on service monitoring concerns)

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Individual Directed Goods and Services

Provider Category:

Individual

Provider Type:

Individuals Hired or Goods Purchased by Participants Who Self-direct

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The state will verify that individuals meet the following qualifications:
- Meets any applicable state regulations for the type of supply or service as described in the approved Individual Plan of Care

Prior to Employment
- Be at least 18 years of age
- Have high school or equivalent degree
- Comply with all SCDHHS standards including regulations, policies and procedures related to provider qualifications
- Complete SCDHHS required training, including training on the youth's person-centered plan and the youth's unique needs, which may include, but is not limited to, communication, mobility and behavioral needs
- Pass a South Carolina criminal history background check, child abuse and neglect screen, motor vehicle screens, and excluded provider screen
- Have a valid driver's license from South Carolina or a contiguous state if the operation of a vehicle is necessary to provide the service

Verification of Provider Qualifications

Entity Responsible for Verification:

SCDHHS or its designee

Frequency of Verification:

Upon contracting and when used thereafter (or more frequently based on service monitoring concerns)

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

- ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

- ☒ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
- ☐ **As a Medicaid state plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
- ☒ **As a Medicaid state plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
- ☐ **As an administrative activity.** *Complete item C-1-c.*
- ☐ **As a primary care case management system service under a concurrent managed care authority.** *Complete item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

Wraparound facilitators must meet conflict of interest, be certified as meeting High Fidelity Wraparound standards, must meet all other provider criteria as outlined in the High Fidelity Wraparound service definition.

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. Criminal History and/or Background Investigations. Specify the state's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

- ○ **No. Criminal history and/or background investigations are not required.**
- ◉ **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

All providers seeking enrollment to provide waiver services are required to receive State level criminal history checks through South Carolina Law Enforcement Division (SLED). The background checks must be updated annually. SCDHHS ensures such documentation has been obtained as a condition to enrollment. SCDHHS verifies annual updates have been obtained during annual QA reviews. This investigation is the meaning of the following statement throughout this waiver: "pass a South Carolina criminal history background check".

b. Abuse Registry Screening. Specify whether the state requires the screening of individuals who provide waiver services through a state-maintained abuse registry (select one):

- ○ **No. The state does not conduct abuse registry screening.**
- ◉ **Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

The South Carolina Department of Social Services (SCDSS) maintains an abuse registry for the State. All providers seeking enrollment to provide waiver services are required to conduct abuse registry screening on employees. SCDHHS ensures such documentation has been obtained as a condition to enrollment. Providers are responsible for ensuring that all employees, contracted workers and volunteers who have direct contact with participants in the waiver have been screened. The screenings must be updated annually. SCDHHS verifies annual updates have been obtained during annual QA reviews. This investigation is the meaning of the following statement throughout the waiver: "pass a child abuse and neglect screen".

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:*

- ◉ **No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**
- ○ **Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The**

standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under state law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the state, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one*:

- (●) **No. The state does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- ( ) **Yes. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) state policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the state ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the state policies specified here.*

- [ ] **Self-directed**
- [ ] **Agency-operated**

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify state policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

- (●) **The state does not make payment to relatives/legal guardians for furnishing waiver services.**
- ( ) **The state makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

- ( ) **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

○ **Other policy.**

Specify:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

Any willing and qualified provider has the opportunity to enroll as a Medicaid provider of waiver services. All potential providers are required to execute a Medicaid provider agreement and accept the State's payment for services rendered. Providers are also required to meet the provider qualifications, as set forth in this waiver.

Providers enroll utilizing the SCDHHS provider enrollment system to ensure that all required checks and credentials are obtained prior to providers being allowed to provide Medicaid and waiver services.

Upon program implementation, South Carolina's only HFW entity the COC, will be available to provide initial support for the PCSC program. A second HFW entity will be added as soon as the provider is able to obtain national accreditation. Taking into consideration the projected estimate of PCSC participants in the first year of program implementation accompanied with the tasks to be performed, we believe this initial provider capacity is sufficient and will allow for a maximum 1:10 HFW facilitator to participant ratio. There will be a need for another HFW entity that SCDHHS contracts with that specializes in children in state custody. A contractor will be added to serve the population as soon as it is available.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

a. ***Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of new HCBS providers that meet initial licensure and/or certification enrollment requirements. Numerator - number of new HCBS providers meeting initial licensure/certification requirements during the waiver year Denominator - total number of new HCBS providers during the waiver year

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of existing HCBS providers that continue to meet licensure and/or certification enrollment requirements at re-enrollment or review. Numerator – number of existing HCBS providers assessed for compliance during the waiver year that continue to meet requirements Denominator – total number of existing HCBS providers assessed for requirements compliance during the waiver year

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of enrolled HCBS providers completing annual background/registry check waiver requirements. Numerator – number of enrolled providers with a completed background/registry check during the waiver year Denominator – total number of enrolled HCBS providers due for a background/registry check during the waiver year

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: HCBS Providers	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of non-licensed HCBS providers with an annual background/registry check. Numerator – number of non-licensed HCBS staff with a completed background/registry check during the waiver year Denominator – total number of non-licensed HCBS staff due for a background/registry check during the waiver year

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample**

		Confidence Interval =
☒ **Other** Specify: HCBS Providers	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of CME staff who meet High Fidelity Wraparound (HFW) training requirements. Numerator – number of HCBS HFW staff meeting training requirements during the waiver year Denominator – total number of HCBS HFW staff during the waiver year

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of HCBS respite providers whose staff meet respite care training requirements. Numerator – number of respite care providers whose staff meet respite care training requirements Denominator – Total number of HCBS respite care providers during the waiver year

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative**

		Sample Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

When issues are discovered by SCDHHS through the formal quality review processes, the responsible party is notified by SCDHHS staff in writing. SCDHHS staff identify the problem, make the responsible party aware of the problem, and ensure that they have appropriate information to correct the problem. If SCDHHS deems the issue to cause imminent danger to the waiver operations or participant, SCDHHS notifies the responsible party and they are restricted from conducting waiver related supports and services until the issue is resolved and SCDHHS accepts the corrective action plan (CAP). Once written notification is received, the CAP must be submitted within 30 days to SCDHHS. The CAP addresses both immediate problems and identifies how the problems will be avoided in the future. SCDHHS reviews corrective action plans to ensure that they address the underlying issues. Failure to submit and implement a corrective action plan may result in being excluded from Medicaid.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

◉ **Not applicable**- The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

○ **Applicable** - The state imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

☐ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

☐ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

☐ **Other Type of Limit.** The state employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.

2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

Individuals eligible for 1915(c) waiver services live in their own home or with families or friends in the same manner as any individual not receiving HCBS. As a new program, the PCSC waiver requires all provider settings and participant residences to comply with the HCBS final rule prior to implementation.

All services covered by the waiver are provided to participants who reside in home and community-based settings that meet HCBS characteristics (i.e., are integrated in and support full access of participants receiving Medicaid HCBS to the greater community, allow participants to engage in community life, to control personal resources and to receive services in the community to the same degree as individuals not receiving Medicaid HCBS). All waiver services providers receive training on the person-centered plan of care of the participant. The services covered by the waiver are designed to be delivered in community settings including, but not exclusively in the participant's home.

High Fidelity Wraparound (HFW)
The wraparound facilitator shall observe the residence of all participants receiving HCBS waiver services and ensure that settings meet the standards at 42 CFR 441. 301(c)(4) at enrollment and annually through regular health and welfare monitoring. The wraparound facilitator's responsibility is to ensure participant and team involvement in decisions that affect individual care, daily schedules and lifestyle. Wraparound facilitators will engage team members to promote an overall atmosphere conducive to the achievement of optimal independence, safety and personal development by the participant. The wraparound facilitators shall document home and community-based settings observations in the case management system. SCDHHS monitors, reviews and validates compliance with the setting requirements and enforces compliance actions as necessary. Verification occurs at enrollment, annually or when the participant's residence changes.

In the event the need for an out of home placement arises for a participant receiving HCBS waiver services, the state certifies all residences will be observed by the wraparound facilitator to ensure settings are in the community the state certifies all residences will be observed to ensure settings are in the community and meet the standards at 42 CFR 441.301 (c)(4) as well as (vi)(A through F) for provider-owned and controlled settings, at placement and on an ongoing monthly basis through regular health and welfare monitoring.

In the case of Foster Care and Therapeutic Foster Care placements, the state certifies all homes are individually licensed by South Carolina Department of Social Services as foster care homes per S.C. Code Ann. 63-11-10 thru 63-11-790 (Supp 2008). The state will verify that all foster care homes annually meet licensing regulations as established and certified by South Carolina Department of Social Services and meet the standards at 42 CFR 441.301 (c)(4) as well as (vi)(A through F) for provider-owned and controlled settings, at placement and on an ongoing monthly basis through regular health and welfare monitoring.

In the event the need for Group Home placement for a waiver participant arises, the state certifies all residences will be observed by the wraparound facilitator to ensure settings are in the community and meet the standards at 42 CFR 441.301 (c)(4) as well as (vi)(A through F) for provider-owned and controlled settings, at the initial placement and on an ongoing monthly basis through regular health and welfare monitoring. The state will also verify Group Homes meet licensing standards as set forth by SC Code 63-11-30: https://www.scstatehouse.gov/code/t63c011.php and SC Regulation 114-590: https://www.scstatehouse.gov/coderegs/Chapter%20114.pdf.

HCBS settings criteria assessed during the annual licensing process that ensure participant and team involvement in decisions that affect individual care, daily schedules and lifestyle include:
•D. Buildings, Grounds and Equipment.
(7) Personal Effects (b, c) (See page 109)
(8) Activities (b, c, d, e) (See pages (109 – 110)
•E. Services to Children.
(2) Clothing (b, c) (See page 110)
(5) Restraints—(c, d) (See page 111)
(6) Family Relationships/Visitation (a) (See page 112)
(9) Academic and Vocational Training (c, d) (See page 113)
•F. Licensing (4, 6) (See page 116 and 117)

The state will verify only Group Homes not located on an IMD campus may be deemed as residences for waiver participants. The Group Home must meet licensing regulations as established by the South Carolina Department of Social Services and the HCBS standards at 42 CFR 441.301 (c)(4) as well as (vi)(A through F).

The state understands the Centers for Medicare and Medicaid Services, SCDHHS or their representatives may rely on this attestation to determine if home and community based settings conditions pursuant to 42.CFR.441.301(c)(4) as well as (vi)(A through F) are met on an ongoing basis.

Individual Directed Goods and Services (IDGS)
Individual Directed Goods and Services will be rendered in the home setting. Home settings are assessed as described above.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:

Person-centered care plan

a. Responsibility for Service Plan Development. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*

☐ **Registered nurse, licensed to practice in the state**

☐ **Licensed practical or vocational nurse, acting within the scope of practice under state law**

☐ **Licensed physician (M.D. or D.O)**

☒ **Case Manager** (qualifications specified in Appendix C-1/C-3)

☐ **Case Manager** (qualifications not specified in Appendix C-1/C-3).
Specify qualifications:

☐ **Social Worker**
Specify qualifications:

☐ **Other**
Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. *Select one:*

◉ **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**

○ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The state has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

Under High Fidelity Wraparound, the family learns about the child and family team process and selects wraparound facilitator. Once selected, the wraparound facilitator assists the family with choosing other service providers. The child and family team meetings are family driven, participant guided and strengths based. The child and family team determines goals and needed services for the waiver participant based on the level of care assessment and the needs of the participant and their family. The purpose of the person-centered plan development process is to ensure that services are identified and goals are being delivered in a person-centered manner that allows the family to be directly involved in what services and how services are delivered to participant in the waiver. At the family's choice, service providers participate in person-centered plan development meetings at least every 90 days to ensure coordinated quality of care. Child and family team meetings are organized by the wraparound facilitator who coordinates with the family to schedule and invite all parties selected by the family to the meetings. Under extenuating circumstances, team members may use video or phone conferencing to participate in the meetings. In the event that a provider cannot attend the meeting, there must be evidence of a conversation regarding person-centered plan development between the participant/family and the wraparound facilitator documenting that the participant and their designee participated in the development of the person-centered plan. The family and any providers listed on the person-centered plan must sign that they were present for the development of the person-centered plan, signifying agreement with its contents as a condition for authorization by SCDHHS.

The participant and their family have the opportunity during the planning process to decide how their services are delivered, who attends their planning meetings, and who provides services to them.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Referrals are processed by Continuum of Care (COC), who assists the participant/family in obtaining an eligibility screen. If a slot is not available, COC notifies the family and places the participant on a waiting list. The family is contacted when a slot is available. The availability of slots is on a first come, first served basis. Once a slot is open, the participant/family selects a wraparound facilitator. HCBS eligibility begins on the earliest date that all three of the following are in place: the participant is found to meet the targeting, risk factors and level of care (LOC); the participant has a provisional plan of care (crisis plan) or final person-centered plan; and a financial eligibility determination is effective. The provisional plan of care (crisis plan) may be in effect for no more than 60 days. Participants who have agreed to community-based services under the waiver and meet all LOC and financial eligibility requirements are placed in a waiver slot, when there is one available. COC informs the family of their eligibility status for the waiver.

If a participant is found eligible, COC conducts a LOC assessment. COC makes a referral to SCDHHS for applicants in need of a Medicaid eligibility determination.

During the initial LOC assessment meeting, the family is required to complete all necessary paperwork. They are asked to sign a freedom of choice form, indicating that they are choosing community-based services. Any additional financial documentation collected is sent to the eligibility worker to support the eligibility determination.

Once the wraparound facilitator is selected, the licensed practitioner of the healing arts (LPHA) or the state public agency employee credentialed to complete the assessment is responsible for completing the CASII, gathering all documentation necessary to substantiate LOC, and scoring the CASII. All information gathered is utilized to determine the CASII score. The CASII score determines LOC eligibility. The Child and Adolescent Functional Assessment Scale (CAFAS) can be used in the development of the person-centered plan and to monitor the participant's progress.

The CASII is also completed upon disenrollment and any time when a significant change in identified risk factors or family strengths is observed or a decision regarding changes in LOC is required. The person-centered plan will address all needs addressed in both the CASII and CAFAS. SCDHHS understands that the CAFAS is a more complete tool for service planning while the CASII is a better eligibility tool. The assessments and recommendation on LOC eligibility are sent to SCDHHS indicating hospital placement, waiver services or other recommendations. SCDHHS reviews the recommended LOC.

Once the participant is functionally eligible for the waiver, the wraparound facilitator meets with the family, provides information about the waiver, and answers any questions the family may have about the waiver process. The wraparound facilitator discusses needed services with the family, based on the needs of the family and youth, and the recommendations from the CASII and CAFAS assessment. The family chooses who they would like to participate in the person-centered plan development process and chooses the time and location of the meeting. The wraparound facilitator works with the participant and family to convene a child and family team meeting. The child and family team discusses the waiver and the criteria for eligibility with the family. Applicants for the waiver are required to provide the wraparound facilitator with documentation to substantiate the information exchanged throughout the eligibility process. The documentation must support the need for waiver services. Once eligibility is determined and the wraparound facilitator is certain that the participant is eligible, the team begins the process of developing a person-centered plan that addresses the goals and needs of the participant. Employees of COC who will be developing the service plan are public employees and LPHAs.

Prior to the first child and family team meeting, the LOC assessment and the eligibility screen will be used to develop a provisional person-centered plan (crisis plan). The family may begin receiving services developed in the provisional person-centered plan (crisis plan) after all eligibility requirements have been met and they are enrolled in the waiver if there are immediate service needs. The provisional person-centered plan (crisis plan) is valid no more than 60 days from the date the child is admitted to the waiver. The first meeting to develop the initial person-centered plan must be held within 30 days from the date the participant is admitted to the waiver.

The wraparound facilitator (qualifications specified in Appendix C-1/C-3) is responsible for facilitating a participant and family team in developing the person-centered plan. The team consists of the participant, family, wraparound facilitator, and anyone else that the participant or family wants to participate. The child and family team is responsible for reviewing the current person-centered plan, summarizing progress, and suggesting goals and direction for services going forward in a family-driven, youth-guided manner. The wraparound facilitator is responsible for planning and coordinating the child and family team meetings. The wraparound facilitator is also responsible for writing the person-centered plan based on

the High Fidelity Wraparound process and feedback and discussion at any child and family team meetings. The wraparound facilitator is also responsible for the completion of other required paperwork following the meetings.

At the child and family team meetings, the team determines what services are needed to maintain the participant in the home. Information gathered from the initial assessment is used to support this process. The person-centered plan includes a crisis plan that clearly signifies the protocol and responsibility for handling crises, including after-hours calls. The person-centered plan must contain all items required in the HCBS regulations.

The Service Plan Development (SPD) Team makes individualized service recommendations for the participant based on assessed needs. The SPD Team makes recommendations to the participant based on the available service array. All recommended services (State Plan, other state agency, community resources, etc.) are added to the individualized plan of care by the Wrap Facilitator. Waiver respite and self-directed goods and services are authorized by COC and approved by SCDHHS waiver staff. All other services are authorized per the State Plan or individual service provider guidelines.

Once the child and family team facilitates the person-centered plan, the team signs that they were present and that they agree with the plan of care. The family/participant then selects providers from a list of qualified providers. When the person-centered plan has been developed and signed by the wraparound facilitator, the family, participant, and the providers, the wraparound facilitator submits the person-centered plan of care to SCDHHS for final approval. Once approved, the wraparound facilitator coordinates with the family and service providers to begin services.

The child and family team is required to meet at least every 90 days beginning from the date the initial person-centered plan was approved. This time frame is the minimum requirement. The family can request a meeting at any time.

Providers of services, at the participant and family's option, should participate in child and family team meetings and give updates on progress. Under extenuating circumstances, a provider may utilize the use of video conferencing or phone conferencing methods to participate in meetings. The family and team members will use this time to review the person-centered plan and discuss any issues or concerns. The person-centered plan is reviewed and changed as needed. The plan must include all the required elements prior to being authorized by COC.

The person-centered plan is the map for the family to ensure that there are sufficient supports and services for the participant to be supported in the home. The person-centered plan includes appropriate identifying information: the participant's name, case management system ID number, date of birth and date of the plan. The person-centered plan identifies strengths and support needs for the waiver youth. Someone reading the person-centered plan should be able to clearly understand the reasons the youth is receiving waiver services. The plan identifies the provider of the service, type of service, frequency, and duration of the service. The person-centered plan identifies goals for each service type that the youth, their family, and the team have identified through the person-centered plan development process. Goals are stated from the perspective of the youth to reinforce the person-centered emphasis on waiver supports and services. Where appropriate, the person-centered plan details how the staff, clinician, or provider supports the waiver youth to reach their goal. Identifying goals and staff actions provides direction to the providers and ensures that providers understand what the supports and services should be based on the clinical recommendations and the preferences of the participant and family. Identifying goals and staff actions on the person-centered plan ensures that providers are accountable for actively addressing the goals that the child and family would like to reach with waiver services.

The person-centered plan must include the following:

• The person-centered plan must reflect the services and supports that are important for the participant to meet the needs identified through an assessment of functional need, as well as what is important to the participant with regard to preferences for the delivery of such services and supports. Commensurate with the level of need of the participant and the scope of services and supports available under the State's 1915(c) Home and Community Based Settings (HCBS) waiver, the written plan must:

o Reflect that the setting in which the participant resides is chosen by the participant. The State must ensure that the setting chosen by the youth is integrated in, and supports full access of, the participant 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 youth not receiving Medicaid HCBS.
o Reflect the youth's strengths and preferences.

o Reflect clinical and support needs as identified through an assessment of functional need.
o Include individually identified goals and desired outcomes.
o Reflect the services and supports (paid and unpaid) that assists the participant to achieve identified goals, and the providers of those services and supports, including natural supports. Natural supports are unpaid supports that are provided voluntarily to the youth in lieu of 1915(c) HCBS waiver services and supports.
o Reflect risk factors and measures in place to minimize them, including individualized back up plans and strategies when needed.
o Be understandable to the participant receiving services and supports, and the individuals important in supporting him or her. At a minimum, for the written plan to be understandable, it must be written in plain language and in a manner that is accessible to youth with disabilities and persons who are limited English proficient, consistent with 42 CFR §435.905(b).
o Identify the participant or entity responsible for monitoring the plan.
o Be finalized and agreed to, with the informed consent of the participant in writing, and signed by all participants and providers responsible for its implementation.
o Be distributed to the participant and other people involved in the plan.
o Include those services, the purpose or control of which the youth elects to self direct.
o Prevent the provision of unnecessary or inappropriate services and supports.
o Document that any modification of the additional conditions, found at 42 CFR § 441.301 under paragraph (c)(4)(vi)(A) through (D), must be supported by a specific assessed need and justified in the person-centered plan. The following requirements must be documented in the person-centered plan:
• Identify a specific and individualized assessed need.
• Document the positive interventions and supports used prior to any modifications to the person-centered plan.
• Document less intrusive methods of meeting the need that have been tried but did not work.
• Include a clear description of the condition that is directly proportionate to the specific assessed need.
• Include a regular collection and review of data to measure the ongoing effectiveness of the modification.
• Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
• Include informed consent of the participant.
• Include an assurance that interventions and supports will cause no harm to the participant.
Review the person-centered plan at least every 3 months, and revise upon reassessment of functional need when the youth’s circumstances or needs change significantly, or at the request of the participant.

The Continuum of Care monitors all service plans. COC and SCDHHS jointly monitor the implementation of the plan.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

A provisional crisis plan is created during the waiver eligibility phase as an immediate plan of action for applicants. The provisional crisis plan describes the family vision and details the strengths of the individual, family and the Wrap Facilitator. The plan also captures the diagnosis (es), brief history, triggers, and potential crisis (es) along with specific action steps for common settings (home, school, etc.). Tasks/Roles are assigned to each team member. Contact information is provided for all team members and service providers identified on the plan.

If the individual is eligible and chooses to participate in the waiver, the provisional plan of care is reviewed at the first child and family team meeting. Applicable components of the provisional crisis plan are incorporated into the individualized plan of care. Additionally, once applicants are enrolled an individualized crisis plan is created. The plan is monitored and updated as necessary.

Potential risks to the youth are identified through the CAFAS, the initial assessment and annual re-assessments. Specific issues are addressed during the child and family team meetings. The person-centered plan includes a crisis plan to help mitigate these identified risks. The child and family team develops the crisis plan taking into account natural and professional supports that are available to the family. The protocol to address crises as well as the providers required to respond is clearly noted in the crisis plan. The person-centered plan is not considered valid by SCDHHS if these components are not included.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

Families are fully informed about how the person-centered plan development process works by the wraparound facilitator and by the child and family team. The family is informed and asked to sign off on a freedom of choice form to ensure and document that each youth is aware of their right to choose from among available provider resources. Families are informed that at any time, they have the option of changing service providers when resources are available. A wraparound facilitator provides this information during enrollment.

In addition, the child and family team serves as an advisory board for the youth and family to support them in making informed decisions about the services they receive and the providers they choose. The child and family team is made up of the youth, family, wraparound facilitator and, at the youth's option, all the service providers as well as anyone else that the youth and family would like to participate.

Youth and their families are given contact information for the wraparound facilitator as well as contact information for staff at SCDHHS. Families are encouraged to bring their concerns to the local level and move up to the chain of command, if needed. If they feel they are not getting appropriate action, they can contact SCDHHS at any time.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

The wraparound facilitator is responsible for writing the person-centered plan that has been agreed upon by the child and family team. The wraparound facilitator ensures that a document showing attendance, the date, and agreement to the plan is signed by all team members, including the family and youth. The person-centered plan, along with the proposed budget and crisis plan, are submitted to SCDHHS for review. If SCDHHS needs more information or clarification about the plan, the wraparound facilitator is notified.

Once the person-centered plan is reviewed by SCDHHS, the wraparound facilitator must send a full copy of the person-centered plan to each of the service providers, as well as a copy for the family and youth.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ○ **Every three months or more frequently when necessary**
- ◉ **Every six months or more frequently when necessary**
- ○ **Every twelve months or more frequently when necessary**
- ○ **Other schedule**

Specify the other schedule:

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies):*

- ☒ **Medicaid agency**
- ☒ **Operating agency**
- ☒ **Case manager**
- ☐ **Other**

Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

a) The wraparound facilitator, COC and SCDHHS are the entities that are responsible for monitoring the implementation of the person-centered plan and ensuring participant health and welfare.

b) After the person-centered plan is reviewed by SCDHHS, the wraparound facilitator assists with coordinating and setting up appointments for the services listed in the person-centered plan. Once a service has been authorized and approved, COC staff prints and presents a listing of all service providers to the participant. The participant provider of choice selection is captured on the document. The original listing and the participant choice documents are uploaded into the participant record. SCDHHS reviews the listings to ensure all providers are included and to verify the participant choice selection is documented. SCDHHS accesses the IT system to monitor compliance of this process.

The wraparound facilitator is required to contact the family a minimum of twice a month to monitor and oversee that the family can access all services listed on the person-centered plan. Per the High Fidelity Wraparound model, at least one of the contacts must be face-to-face with the family. All contacts must be documented, and all documentation must include the participant's name, case management system ID, date of service, duration of service, location or mode of contact, and must identify case management activities that were provided during the time frame. The service documentation must be signed, titled, and dated by the child and family team member who rendered the service. Services and behaviors are reviewed monthly. The wrap facilitators and COC staff update the participant record with clinical observations and participant progress. During subsequent meetings and the service plan review meeting, data is reviewed to determine if service plan modifications are required. The child and family team determines if participant needs are being met by the service plan. Services that are not billable are documented the same way to show progress in treatment. Modifications are made to the plans when necessary. Both waiver and non-waiver services listed on the person-centered plan are monitored by the wraparound facilitator. SCDHHS performs oversight of this process.

The child and family team is required to meet at least every 90 days to review the person-centered plan and discuss progress or any changes that may be needed. In addition, if issues arise concerning implementation or participant health or welfare, the family can call a child and family team meeting at any time. In addition, families can contact their wraparound facilitator or SCDHHS directly at any time to discuss any issues that may arise.

When a crisis occurs a crisis team meeting is held and the crisis plan is reviewed and modified if necessary.
Follow-up and remediation of identified problems should occur at the local level first and then move up the chain of command, if needed. The wraparound facilitator is required to promptly address any concerns the family may have about the implementation of the person-centered plan and any participant health and welfare issues. If the concerns cannot be addressed at this level, the participant/family may also contact another member of the child and family team to intervene if they do not feel comfortable having the wraparound facilitator do this for them. SCDHHS is notified when attempts to resolve concerns are unsuccessful. The family may also use the grievance process to address a concern.

c) SCDHHS reviews the person-centered plan each time a new plan is developed to authorize waiver services and for quality purposes for each participant. SCDHHS also conducts an annual quality review to verify that services were provided in accordance with the person-centered plan. Concerns discovered during those reviews are further investigated by SCDHHS.

b. Monitoring Safeguards. *Select one:*

- ◉ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- ○ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

The state has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

a. ***Sub-assurance: Service plans address all participants assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of newly enrolled participants whose person-centered plans address their needs identified during the assessment process. Numerator – number of newly enrolled participants whose person-centered plans address their needs identified during the assessment process Denominator – total number of newly enrolled participants during the waiver year

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% and a +/- 5 percent margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of newly enrolled participants whose person-centered plans address their personal goals identified during the assessment process. Numerator – number of newly enrolled participants whose person-centered plans address their personal goals identified during the assessment process Denominator – total number of newly enrolled participants during the waiver year

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% and a +/- 5 percent margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of existing participants whose person-centered plans address their needs identified during the assessment process. Numerator – number of existing participants whose person-centered plans address their needs identified during the assessment process Denominator – total number of enrolled participants during the waiver year

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% and a +/- 5 percent margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of existing participants whose person-centered plans address their personal goals identified during the assessment. Numerator – number of existing participants whose person-centered plans address their personal goals identified during the assessment Denominator – total number of enrolled participants during the waiver year

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% and a +/- 5 percent margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Other** Specify:

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of service plans that involved participants and/or responsible parties in the development process during the waiver year. Numerator – number of service plans that involved participants/responsible parties during the waiver year Denominator - total number of plans reviewed during the waiver year

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other**	☒ **Annually**	☐ **Stratified**

Specify:		Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participants needs.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of person-centered plans updated every six months. Numerator – number of person-centered plans updated every six months Denominator - total number of plans due for bi-annual review during the waiver year

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% and a +/- 5 percent margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of person-centered plans updated as participants needs change.
Numerator – number of person-centered plans updated as participant needs change
Denominator - total number of plans reviewed with changing participant needs during the waiver year

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% and a +/- 5 percent margin of error
☐ **Other**	☒ **Annually**	☐ **Stratified**

Specify:		Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of participants who received services as identified in the person-centered plan. Numerator – number of participants who received services as identified in the person-centered plan Denominator – total number of participants who received services during the waiver year

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% and a +/- 5 percent margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of participants who received services in the amount as identified in the person-centered plan. Numerator – number of participants who received services in the amount as identified in the person-centered plan Denominator – total number of participants who received services during the waiver year

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% and a +/- 5 percent margin of error

☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of participants who received the service type identified in the person-centered plan. Numerator – number of participants who received the service type identified in the person-centered plan Denominator – total number of participants who received services during the waiver year

Data Source (Select one):

Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% and a +/- 5 percent margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other**	☒ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
Specify:	
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of participants who received services in accordance with the frequency identified in the person-centered plan. Numerator – number of participants who received services in accordance with the frequency identified in the person-centered plan Denominator – total number of participants who received services during the waiver year

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% and a +/- 5 percent margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of participants who received services in accordance with the duration identified in the person-centered plan. Numerator – number of participants who received services in accordance with the duration identified in the person-centered plan Denominator – total number of participants who received services during the waiver year

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data	**Frequency of data collection/generation**	**Sampling Approach** *(check each that applies):*

collection/generation *(check each that applies):*	*(check each that applies):*	
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% and a +/- 5 percent margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

e. ***Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of participants/responsible parties afforded choice among waiver services and/or qualified providers when available. Numerator – number of participants/responsible parties notified of their rights to choose among waiver services and or/qualified providers when available Denominator - total number of participants enrolled during the waiver year

Data Source (Select one):
Other
If 'Other' is selected, specify:
Freedom of Choice form verification

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence

		Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

When issues are discovered by SCDHHS through formal quality review processes, the responsible party is notified by SCDHHS staff. SCDHHS staff identifies the problem, makes the responsible party aware of the problem and ensures that they have appropriate information to correct the problem. SCDHHS staff formally issues a statement of deficiency requiring a corrective action plan (CAP). If SCDHHS deems the problem/issue/concern to cause imminent danger to the waiver operations or youth, SCDHHS notifies the responsible party and the responsible party is restricted from conducting waiver related supports and services until the issues are resolved and SCDHHS accepts the CAP. Once written notification is received, the CAP must be submitted within 30 days to SCDHHS. The corrective action plan addresses both immediate problems and identifies how the problems will be avoided in the future. SCDHHS reviews corrective action plans to ensure that they address the underlying issues/concerns. Failure to submit and implement a corrective action plan may result in being excluded from Medicaid.

When issues/problems/concerns are discovered by SCDHHS through informal processes, the responsible party is contacted by SCDHHS staff. SCDHHS staff identifies the problem, makes the responsible party aware of the problem and ensures that they have appropriate information to correct the problem. If SCDHHS deems the problem/issue/concern to cause imminent danger to the waiver operations or youth, SCDHHS ensures that immediate action is taken to protect the health and welfare of the participant, issues a formal notice of deficiency, and notifies the responsible party. If the issue/problem/concern is of a less serious nature, SCDHHS staff documents the contact and the request for correction to ensure that there is timely and appropriate follow up. The responsible party is given an opportunity to correct the problem informally and submit corrections to SCDHHS staff. If the problem is not addressed in a timely way, SCDHHS staff formally issues a statement of deficiency requiring a corrective action plan. Once written notification is received, the CAP must be submitted within 30 days to SCDHHS. The corrective action plan addresses both immediate problems and identifies how the problems will be avoided in the future. SCDHHS reviews corrective action plans to ensure that they address the underlying issues/concerns. Failure to submit and implement a corrective action plan may result in being excluded from Medicaid.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
	Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

- (●) **No**
- ( ) **Yes**

  Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

- (●) **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
- ( ) **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

- ( ) **Yes. The state requests that this waiver be considered for Independence Plus designation.**
- (●) **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

This waiver offers participants and their representatives to self-direct only the Individual Directed Goods and Services under the Budget Authority. The participant or his/her guardian can choose to direct the participant care for this one service. This allows them to contract with the entity of their choice to address the identified need in the participant person-centered plan that is not otherwise provided or supplied under this waiver or through the Medicaid State Plan.

Participant/family must have no communication or cognitive deficit that would interfere with their ability to self-direct individual directed goods and services.

High Fidelity Wraparound Facilitators will provide detailed information to the participant or family about individual directed goods and services. They will also explain participant/family direction as an option, including the benefits and responsibilities of the option. If the participant or family wants to pursue this service, additional information about the risks, responsibilities and liabilities of the option is shared. Once the participant or family has chosen to direct their individual directed goods and service, wraparound facilitators continue to monitor service delivery and the status of the participant health and safety.

Information about individual directed goods and services and the role of the Financial Management Services (FMS) entity is also provided. The self-directed participant accesses FMS through the financial management services entity. The FMS entity is an administrative contractor authorized by SCDHHS to provide reimbursement for individual directed goods and services. Under this model, the FMS entity provides purchasing supports to participants who self-direct individual directed goods and services. The contract with the FMS entity ensures the participant can exercise budget authority to purchase goods on the approved person-centered plan of care.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one*:

- ○ **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- ◉ **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- ○ **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies*:

- ☒ **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
- ☐ **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
- ☐ **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy *(select one):*

- ○ **Waiver is designed to support only individuals who want to direct their services.**
- ○ **The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**
- ◉ **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the state. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

The participant or family must have no communication or cognitive deficits that would interfere with participant or family direction of individual directed goods and services. The wraparound facilitator assesses and determines that these criteria are met. Participants interested in self-direction are prescreened to ensure these criteria are met utilizing a standardized prescreen form used in other SCDHHS waivers. The prescreening form is standardized across waiver programs and assesses three main areas of ability that are critical to self-direction and assuring the health and welfare of the participant. These include communication, cognition patterns, and mood and behavior patterns. The communication section assesses the ability of the participant or guardian to make themselves understood and the ability of others to understand the participant or guardian. The cognitive patterns section evaluates both the short-term memory and cognitive skills for daily decision-making of the participant and guardian. Finally, the assessment tool reviews the mood and behavior patterns of the participant or guardian to assess sad or anxious moods. The assessment is scored based on these three areas and the results are shared with the participant or guardian. If the participant or guardian disagrees with the results, they may appeal the decision. and Continuum of Care (COC) assesses the cognitive and communication abilities of participant/family members who wish to direct some of their waiver services. This process is consistent for all participants meeting the level of care (LOC) for this waiver.

Because individual directed goods and services is the only service being self-directed, the standardized pre-screen form is not anticipated to be a barrier to most families wishing to self-direct this service.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

At the time of the initial child and family team meeting, if individual directed goods and services is identified as a beneficial service for the participant or family, the wraparound facilitator introduces participant direction of individual directed goods and services and provide a brochure giving information about this option. If the participant/guardian is interested, the wraparound facilitator provides more details about the benefits and responsibilities of participant direction and determines continued interest. The wraparound facilitator provides information about the benefits as well as the risks, responsibilities and liabilities of participant direction. If not initially interested, the wraparound facilitator continues to assess the participants needs and interest on an annual basis.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. Participant Direction by a Representative. Specify the state's policy concerning the direction of waiver services by a representative *(select one):*

○ **The state does not provide for the direction of waiver services by a representative.**

◉ **The state provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

☒ **Waiver services may be directed by a legal representative of the participant.**

☒ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.** Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

A participant may choose to have waiver services directed by a representative and he/she choose anyone (subject to SCDHHS or Medicaid policy) willing to understand and assume the risks, rights and responsibilities or directing the participants care. The chosen representative must demonstrate a strong personal commitment to the participant and knowledge of the participant preferences. The representative must be willing to complete the necessary paperwork and serve as the employer of record. The representative must be at least 21 years of age.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Individual Directed Goods and Services	☐	☒

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

◉ **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i).*

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

☐ **Governmental entities**

☒ **Private entities**

○ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one*:

○ **FMS are covered as the waiver service specified in Appendix C-1/C-3**

The waiver service entitled:

◉ **FMS are provided as an administrative activity.**

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

The state will contract with a single source private entity to provide financial management services. This organization will serve as an Agency with Choice provider type.

Procurement of FMS services was initiated with the release of a State of South Carolina Best Value Bid Solicitation. Multiple bids were received and evaluated. A contractual agreement was established with the selected entity. Participant and provider records associated with this contractual agreement are maintained in HIPAA compliant manner and consistent with IRS-DOL, Medicaid, and State of SC requirements.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

SCDHHS compensates the FMS entity through administrative funds. The payment to the FMS entity does not affect the participant waiver budget. The scope of supports provided by the FMS entity includes:
- Processing, filing, and payment of applicable federal, state, and local taxes and insurances.

SCDHHS monitors the performance of the FMS entity by monitoring expenditures each month. Additionally, an independent audit of the FMS entity is conducted yearly.
- The FMS entity will receive a monthly fee for only those participants opting to direct services.

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide *(check each that applies)*:

Supports furnished when the participant is the employer of direct support workers:

☐ **Assist participant in verifying support worker citizenship status**

☐ **Collect and process timesheets of support workers**

☐ **Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**

☒ **Other**

Specify:

The FMS entity will receive and disburse funds for the payment of goods and services on behalf of the participant. The wraparound facilitator's role is separate and distinct from the role of the FMS entity. In accordance with the service plan, the wraparound facilitator will enter requests for goods and services in the case management system. If authorized by SCDHHS, the wraparound facilitator will work with SCDHHS to ensure the authorized good is purchased and received by the participant. The FMS entity will monitor and generate periodic reports of expenditures for participants who self-direct.

Supports furnished when the participant exercises budget authority:

☒ **Maintain a separate account for each participant's participant-directed budget**

☒ **Track and report participant funds, disbursements and the balance of participant funds**

☒ **Process and pay invoices for goods and services approved in the service plan**

☒ **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**

☐ **Other services and supports**

Specify:

Additional functions/activities:

☒ **Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**

☒ **Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**

☒ **Provide other entities specified by the state with periodic reports of expenditures and the status of the participant-directed budget**

☒ **Other**

Specify:

Receive and disburse funds for the payment of participant-directed services under an agreement with SCDHHS.

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

An annual independent audit is required to verify that expenditures are accounted for and disbursed according to General Accepted Accounting Practices. SCDHHS will monitor the FMS entity through the case management system. Individual directed goods and services requested, authorized, procured and received will be monitored in the transaction history of the case management system. Budget management will also be monitored in the case management system.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☒ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

The wraparound facilitator provides any information regarding self-direction of individual directed goods and services necessary for the participant and ensures that the participant is aware of how to work with the FMS entity to ensure that the goods and services are reimbursed properly.

☒ **Waiver Service Coverage.**

Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
High Fidelity Wraparound	☐
Individual Directed Goods and Services	☒
Respite	☐

☐ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one).*

◉ **No. Arrangements have not been made for independent advocacy.**

○ **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the state accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the state assures continuity of services and participant health and welfare during the transition from participant direction:

The wraparound facilitator accommodates the participant by providing a list of resources (when available) from which a participant may choose to consult to maintain goals met by the acquisition of goods or services. The wraparound facilitator and SCDHHS work together to ensure the health and safety of the youth in this transition and work to avoid breaks in goal maintenance.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the state will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

If the participant or his/her representative is no longer able to communicate or if they experience cognitive deficits which keep them from acting in their best or the participants best interest, the wraparound facilitator transitions services and cease the provision of individual directed goods and services. COC uses written criteria in making this determination. The participant and/or representative is informed of the opportunity and means of requesting a fair hearing and the plan is revised to accommodate changes in the participants person-centered plan necessary for the participant to remain in their home.

When it is determined that participant/family direction of services is no longer appropriate, alternate, provider-directed services are authorized to ensure continuity of care and assure participant health and welfare. This waiver service targets only those participants who elect to self-direct the individual goods and services or have an appropriate family member to do so. However, if waiver participant/family members become unable/unwilling to direct the individual directed goods and services and it becomes necessary to terminate the service, the person-centered plan is modified to accommodate other HCBS services available to ensure continuity of care.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the state's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the state will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1		100
Year 2		125
Year 3		150
Year 4		175
Year 5		200

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

a. Participant - Employer Authority *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both*:

☐ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

☐ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

☐ **Recruit staff**

☐ **Refer staff to agency for hiring (co-employer)**

☐ **Select staff from worker registry**

☐ **Hire staff common law employer**

☐ **Verify staff qualifications**

☐ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

☐ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

☐ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**

☐ **Determine staff wages and benefits subject to state limits**

☐ **Schedule staff**

☐ **Orient and instruct staff in duties**

☐ **Supervise staff**

☐ **Evaluate staff performance**

☐ **Verify time worked by staff and approve time sheets**

☐ **Discharge staff (common law employer)**

☐ **Discharge staff from providing services (co-employer)**

☐ **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

b. Participant - Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-*

1-b:

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

- ☐ **Reallocate funds among services included in the budget**
- ☒ **Determine the amount paid for services within the state's established limits**
- ☐ **Substitute service providers**
- ☒ **Schedule the provision of services**
- ☒ **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
- ☒ **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
- ☒ **Identify service providers and refer for provider enrollment**
- ☒ **Authorize payment for waiver goods and services**
- ☐ **Review and approve provider invoices for services rendered**
- ☐ **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

An individual directed goods and services resource allocation is established for each participant. The individual directed goods and services resource allocation represents a target amount of resources available to the participant for the cost of the supports and services they need.

The budget for Individual Directed Goods and Services is limited to $2,000 lifetime per participant. The $2,000 lifetime maximum is based upon limits in the PRTF CHANCE waiver ($1,940) and other states for similar goods and services (e.g., New York has a $2,000 limit for the same good and service). During implementation of a similarly structured SAMHSA grant program, funds were most often requested for items such as bedding, backpacks and clothing items to support maintenance of the individual in the community.

SCDHHS approves purchases when the following conditions are met: the item is identified on the person-entered plan, the Child and Family Team has determined local resources are not able to provide the requested item, and funds to purchase the item are not available through another source.

IDGS are only paid for by the FMS once the goods or services are verified as received, the goods and services are on the approved service plan, and that the expenditures do not exceed the lifetime limit.

Members of the public can access changes to budget methodology on demand from the SCDHHS website. Changes will be communicated through the Public Notice process. Notices are available on demand by accessing the following SCDHHS link: https://www.scdhhs.gov/search/node/public%20notice. General stakeholder feedback and requests for changes or more information is accepted in writing, via email, by telephone, in person and during scheduled meetings.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

iii. Informing Participant of Budget Amount. Describe how the state informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

Participants and their representatives who choose to direct their services can get information on their individual directed goods and services resource allocation from their wraparound facilitator at the beginning of the planning process. Through the person-centered planning process, the person defines their own specific needs and with the assistance of the individual directed goods and services, designs their own person-centered plan and corresponding budget costs. If the budgeted costs are less than the lifetime value, the plan and the budget are given the streamlined approval. If the budgeted costs exceed the lifetime value, review occurs at the state level to plan for appropriate services within the individual directed goods and services resource allocation target value.

Participants can also request to change any aspect of their self-directed person-centered plan and budget during the implementation phase to achieve evolving personal goals and valued outcomes, and to prevent institutionalization. There are two set opportunities to make changes to the person-centered plan and budget yearly plan or the individual directed goods and services resource allocation which align with the reviews of their person centered plan. Individuals are afforded an immediate opportunity to request a change to their person-centered plan and budget if circumstances occur that imminently threaten the life, safety and/or welfare of the participant. Participant and their representatives are assisted through these change processes by their wraparound facilitator.

All participants receive the SCDHHS Medicaid Appeal Process two-page document as well as a PCSC Grievances and Appeals Brochure. The brochure provides examples of adverse decisions to include suspension, reduction of waiver services or adjustments in budget amounts. Both documents detail the Fair Hearing process, how an appeal is initiated, processed, and resolved. An appeal may be communicated to COC staff or to SCDHHS staff. Complaints regarding services being provided to children by a state agency can be submitted to the SC Department of Children’s Advocacy via email or by phone. This information is also included in the brochure.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

iv. Participant Exercise of Budget Flexibility. *Select one*:

- (●) **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- ( ) **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

There are a number of safeguards and other resources designed to prevent the premature depletion of the participant-directed individualized budget.

The FMS entity tracks expenditures of individual directed goods and services and ensures that the participant does not exceed the budget. A reminder is sent to the participant or family and wraparound facilitator when the funds are 90% expended. The main function of wraparound facilitator related to individual directed goods and services is to assist the participant to manage their individual budget. Wraparound facilitator reviews annual expenditure reports with the participant and their representative to ensure that expenses are appropriate. Child and family teams are required to meet at least once every three months but meets as often as the participant requires to assist with any issues related to the individual directed goods and services resource allocation. Other areas of support include:

- continual identification of revised or emerging valued outcomes and the supports needed to address them;
- on-going planning and maintenance of the self-directed budget;
- review of individualized budget expenditure reports to ensure that available resources remain adequate to meet approved services and supports;
- assistance in ensuring that risk, responsibilities, and consequences are understood and adhered to and that safeguards are revised, if needed, to adequately address needs, and;
- helping to ensure that health and safety concerns are immediately identified and addressed.

The wraparound facilitator is the liaison or authorized designee to the FMS entity for issues related to the co-management of his or her self-directed budget.

A core function of FMS entity is to develop and implement an accounting and information system to track and report participant-directed support funds. The FMS entity makes payments based on a current, approved budget which outlines the annual costs the participant incurs and how these costs are paid over the course of the year. Additionally, the FMS entity ensures that there are sufficient funds available within the participant account to make the necessary payments.

The FMS entity also develops a mechanism to identify those participants who incur expenses in excess of expected spending. Under use of individual directed goods and services is not considered a health and welfare issue unless identified as such by the wraparound facilitator. Either circumstance must immediately be reported to the participant(or authorized designee where appropriate). The FMS entity must also generate detailed support funds and expenditure reports to participant, their representatives, and the wraparound facilitator on a semi-annual basis. These reports must be customized, as appropriate to their intended audience, to ensure that members of the child and family team can understand them.

The contracted FMS entity submits the expenditure reports to the wraparound facilitator who addresses issues related to depleting fiscal resources and over/under-utilization with the participant. The participant works with his or her wraparound facilitator to determine the need to revise the self-directed plan and budget.

An financial management services checklist, which highlights the general responsibilities of the FMS entity, is shared with all participants using the entity to self-direct services. On-going training is also provided to all parties on their roles and responsibilities.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Prior to acceptance into the waiver, the appeals process is provided and explained to applicants when the Freedom of Choice documents are signed.

The formal process of review and adjudication of actions and determinations are performed under the authority of S.C. Code Ann. § 1-23-310 et seq., as amended, and the Department of Health and Human Services regulations Section 126-150, et seq. The participant or representative has the right to request an appeal to the SCDHHS Division of Appeals and Hearings. The purpose of an administrative appeal is to allow the appropriate party to appeal an adverse action or determination from a final agency decision.

An adverse action, as defined in 42 CFR §431.201, includes termination, suspension, or reduction of waiver or Medicaid state plan services on a participants plan of care. An adverse determination, as defined in 42 CFR §431.210, includes denial into the waiver because the participant does not meet the level of care or other criteria. A final agency decision is the completion of an agency's decision making process that would substantially affect a person's rights or benefits.

In order for waiver benefits or services to continue during the appeal process, the appeal must be submitted in writing within ten (10) calendar days of the date of the mailing of the written notification of the adverse decision. If the agency upholds the adverse action or determination, the participant or family may be required to repay waiver benefits received during this appeal process.

The participant or representative must submit an appeal no later than thirty (30) calendar days from the date of the mailing of the written notification of the adverse decision. Appeals can be filed online at https://msp.scdhhs.gov/appeals/site-page/file-appeal ; faxed to (803) 255-8206; or mailed to:

Division of Appeals and Hearings
SC Department of Health and Human Services
PO Box 8206
Columbia, SC 29202-8206

An appeal request is considered filed if received by the thirtieth (30th) calendar day following the date of the mailing of the written notification of the adverse decision. The participant or representative must include a copy of the notification of denial or denials received from SCDHHS regarding the specific matter on appeal. The participant or representative must state with specificity which issue(s) is being appealed.

The participant or representative shall be advised by the SCDHHS Division of Appeals and Hearings as to the status of the appeal request. Unless the request is made as directed above, the agency considers the adverse decision as final.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- (●) **No. This Appendix does not apply**
- ( ) **Yes. The state operates an additional dispute resolution process**

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. Operational Responsibility. Specify the state agency that is responsible for the operation of the grievance/complaint system:

SCDHHS

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

This waiver operates a grievance system that gives families and participants the opportunity to file a complaint. Some examples of grievances include dissatisfaction with a provider, the course of treatment, or with the operating or administrative entity. Examples of issues not appropriate for the grievance process include denial of entry into the waiver, reduction of services, or termination from the waiver. These types of issues may be appealed through the process outlined in Appendix F-1, Opportunity to Request a Fair Hearing.

Families and participants will receive information about the grievance process during enrollment in the waiver. If the participant or family has a grievance, they can contact either the wraparound facilitator, or SCDHHS waiver staff to report the grievance. For example, if the grievance concerns the wraparound facilitator, the participant or family may choose to contact SCDHHS waiver staff. If, however, the grievance concerns a provider, the participant or family may choose to contact the wraparound facilitator. Although the family may choose what person to contact about the grievances, the grievance must be submitted in writing and will not be formally addressed until the written statement is received. Regardless of which entity initially receives the grievance, all grievances shall be reported to SCDHHS waiver staff.

If a wraparound facilitator receives a written grievance, supervisory staff investigates the grievance and schedules a mediation to address the participant or family's concerns. If a SCDHHS waiver staff receives a written grievance, SCDHHS waiver staff investigates the grievance and schedules a mediation to address the participant or family's concerns. If, during the mediation, the parties agree to resolve the grievance, the resolution shall be acknowledged in writing and documented in the participants record at SCDHHS.

If the participant or family is unsatisfied with the outcome of the mediation, either may appeal in writing to the SCDHHS Waiver Director. The wraparound facilitator, or SCDHHS representative can assist the family with this process. SCDHHS must issue a written decision within ten (10) working days from the date of the receipt of the written grievance. If the parties resolve the grievance prior to the written decision, the resolution shall be acknowledged in writing and documented in the participants record at SCDHHS.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program.*Select one:*

- ◉ **Yes. The state operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*

○ **No. This Appendix does not apply** *(do not complete Items b through e)*

If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

An assessment must be administered and submitted within seven days to SCDHHS after any incidents of abuse, neglect, and/or exploitation committed by or to waiver participant. Waiver staff must be notified of any follow-up information available within 48 hours of discovery and all requested follow-up documents have to be submitted to SCDHHS within 48 hours of the request. The CASII is additionally completed upon disenrollment and any time during enrollment when a significant change in identified risk factors or family strengths is observed or a decision regarding changes in level of care is required.

S.C. Code Ann. § 63-7-10 et seq., states that Mandated reporters of abuse, neglect and exploitation must report any allegation of abuse, neglect and exploitation that they become aware of. The reports must be made to those State agencies having statutory authority to receive reports and investigate allegations of suspected abuse, neglect and exploitation. These reports can be made by phone or written form. All verbal reports shall subsequently be submitted in writing.

Definition: "Child abuse or neglect" or "harm" occurs when the parent, guardian, or other person responsible for the child's welfare:

- Inflicts or allows to be inflicted upon the child physical or mental injury or engages in acts or omissions which present a substantial risk of physical or mental injury to the child, including injuries sustained as a result of excessive corporal punishment, but excluding corporal punishment or physical discipline which:
  - is administered by a parent or person in loco parentis;
  - is perpetrated for the sole purpose of restraining or correcting the child;
  - is reasonable in manner and moderate in degree;
  - has not brought about permanent or lasting damage to the child; and
  - is not reckless or grossly negligent behavior by the parents.
- Commits or allows to be committed against the child a sexual offense as defined by the laws of this State or engages in acts or omissions that present a substantial risk that a sexual offense as defined in the laws of this State would be committed against the child;
- Fails to supply the child with adequate food, clothing, shelter, or education as required under Article 1 of Chapter 65 of Title 59, supervision appropriate to the child’s age and development, or health care though financially able to do so or offered financial or other reasonable means to do so and the failure to do so has caused or presents a substantial risk of causing physical or mental injury. However, a child’s absences from school may not be considered abuse or neglect unless the school has made efforts to bring about the child’s attendance, and those efforts were unsuccessful because of the parents’ refusal to cooperate. For the purpose of this chapter “adequate health care” includes any medical or nonmedical remedial health care permitted or authorized under State law;
- Abandons the child;
- Encourages, condones, or approves the commission of delinquent acts by the child and the commission of the acts are shown to be the result of the encouragement, condonation, or approval; or
- Has committed abuse or neglect as described in subsections (a) through (e) such that a child who subsequently becomes part of the person's household is at substantial risk of one of those forms of abuse or neglect.

Reporting critical events or incidents:
A physician, nurse, dentist, optometrist, medical examiner, or coroner, or an employee of a county medical examiner’s or coroner’s office, or any other medical, emergency medical services, mental health, or allied health professional, member of the clergy including a Christian Science Practitioner or religious healer, school teacher, counselor, principal, assistant principal, school attendance officer, social or public assistance worker, substance abuse treatment staff, or childcare worker in a childcare center or foster care facility, foster parent, police or law enforcement officer, juvenile justice worker, undertaker, funeral home director or employee of a funeral home, persons responsible for processing films, computer technician, judge, or a volunteer non-attorney guardian ad litem serving on behalf of the South Carolina Guardian Ad Litem Program or on behalf of Richland County CASA must report in accordance with this section when in the person's professional capacity the person has received information which gives the person reason to believe that a child has been or may be abused or neglected.

If a person required to report has received information that in the person’s professional capacity which gives the person reason to believe that a child’s physical or mental health or welfare has been or may be adversely affected by acts or omissions that would be child abuse or neglect if committed by a parent, guardian, or other person responsible for the child’s welfare, but the reporter believes that the act or omission was committed by a person other than the parent, guardian, or other person responsible for the child's welfare, the reporter must make a report to the appropriate law enforcement agency.

A person, including, but not limited to, a volunteer non-attorney guardian ad litem serving on behalf of the South Carolina Guardian Ad Litem Program or on behalf of Richland County CASA, who has reason to believe that a child's physical or mental health or welfare has been or may be adversely affected by abuse and neglect may report, and is encouraged to report, in accordance with this section.

Reports of child abuse or neglect may be made orally by telephone or otherwise to the county department of social services or to a law enforcement agency in the county where the child resides or is found.

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

At the time of enrollment, the participants are informed of how to report abuse, neglect and exploitation by telephone or otherwise to the county department of social services (if a parent is the abuser) or to a law enforcement agency in the county where the participant resides or is found (if the abuser is not a parent or acting in the place of a parent).

See S.C. Code Ann. § 63-7-450.
The South Carolina Department of Social Services (SCDSS) Protective Services shall inform all persons required to report abuse, of the nature, problem, and extent of child abuse and neglect and of their duties and responsibilities in accordance with State law. SCDSS, on a continuing basis, shall conduct training programs for Department staff and appropriate training for persons required to report.

SCDSS, on a continuing basis, shall inform the public of the nature, problem, and extent of the child abuse and neglect and of the remedial and therapeutic services available to children and their families. SCDSS shall encourage families to seek help consistent with Section 63-7-30.
SCDSS, on a continuing basis, shall actively publicize the appropriate telephone numbers to receive reports of suspected child abuse and neglect, including the twenty-four hour, statewide, toll-free telephone service and respective numbers of the county department offices.

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

Abuse, Neglect and Exploitation Critical Incidents
When there is reason to believe that a waiver participant has been abused, neglected, or exploited, in the home or other community setting, HCBS providers, their employees and other mandated reporters have a duty to report according to established procedures and state law. SCDSS is the mandated agency to investigate suspected ANE in these settings. DHHS and its contracted provider agencies shall be available to provide information and assistance to SCDSS. Procedures and time frames of 30 days have been established for SCDHHS to assist providers in resolving issues with SCDSS regarding intake referrals and investigations. SCDSS will conduct a complete investigation and contact law enforcement if criminal violations are suspected. If the investigation is substantiated, notification by SCDSS is sent to appropriate agencies for required actions to be taken. Within 24 hours or the next day of discovery of the incident, COC creates an incident report in the IT case management system. SCDHHS receives notification of all critical incident entries and monitors incidents until resolution.

Other Reportable Incidents
When there is reason to believe a participant is involved or is suspected to be involved in an event identified by waiver policy as a reportable incident, COC creates a critical incident in the IT case management system. The report is made within 24 hours (or the next business day) of discovery. COC documents notifications have been made to the appropriate authority (if warranted by policy) and the family or guardian (upon discovery unless otherwise noted on the individualized plan of care). COC also incorporates additional relevant information to ensure sufficient measures have been taken to protect the health and welfare of the involved person(s). Depending on the nature of the incident, according to COC policy a procedural review is scheduled within 72 hours to assess the incident and the actions of the Child and Family Team. Revisions to the crisis plan and individualized plan of care are made if warranted. SCDHHS receives notification of all critical incident entries and monitors each incident until resolution.

HCBS providers of services may also create critical incident reports in the IT system when a participant is involved in or suspected to be involved in a reportable event as defined by policy. The report is made within 24 hours (or the next business day) of discovery. When the critical incident report is created COC and SCDHHS is notified of the entry. COC coordinates with the HCBS provider to gather additional relevant information including reports made to authorities and the family or guardian (upon discovery unless otherwise noted on the individualized plan of care) according to established procedures and state law. COC documents steps taken to ensure sufficient measures have been taken to protect the health and welfare of the involved person(s). Per COC policy and when warranted, a procedural review is scheduled within 72 hours to assess the incident and propose crisis plan and individualized plan of care modifications, when recommended. SCDHHS monitors each incident until resolution.

Investigation of ANE Critical Incident Reports
Reports of abuse or neglect for participants under 18 years of age shall be filed in the county South Carolina Department of Social Services (DSS) office - Child Protective Services where the participant resides. Reports may also be filed with the local law enforcement office after which a DSS investigation may occur. Reports of abuse, neglect, or exploitation for participants 18 years of age or older shall be filed in the county DSS office – Adult Protective Services Division where the participant resides. Any incident that rises to the level of crime against a participant is reported immediately to law enforcement.

Investigation of Other Reportable Incident Reports
In addition to monitoring incidents to resolution, incidents will also be reviewed by SCDHHS on a monthly basis to determine types of incidents and trends. Information and findings from oversight activities will be communicated quarterly to the Joint Council on Children and Adolescents (JCCA) - Executive Steering Committee or its designee entity. To prevent re-occurrences, SCDHHS will share trend and report data with the Office of the Deputy Children's Advocate and to the South Carolina Law Enforcement Division (SLED)/Child Fatalities Review Office (if a death occurs). Abuse and neglect occurring in therapeutic foster homes during the provision of respite services will be reported to the Out of Home Abuse and Neglect Investigations unit (OHAN).

Evaluation of Critical Incident and Other Reportable Incident Reports
SCDHHS evaluates the critical incident reports to ensure:

- Prompt action was taken to protect the health, safety and welfare of the involved person(s), this includes but is not limited to contacting emergency services, crisis management, Law enforcement, etc., coordinating counseling, medical care or evaluations.
- Mandatory reporting requirements were met by contacting appropriate protective services agency, when applicable.
- Law enforcement (SLED) was notified as appropriate.

- Prompt notification to the family or guardian, when applicable.
- The incident was correctly categorized.
- Safeguards to prevent reoccurrence are established and documented.
- Changes were made to the crisis plan or the individualized plan of care, when warranted.
- The family or guardian received notification of findings.

SCDHHS monitors all incident reports and provides a final status update within 45 days of accepting the initial critical incident report.

Identification of Unreported Incidents
SCDHHS staff identify unreported incidents during the performance of general waver oversight and monitoring. When an unreported incident is discovered, the reviewer communicates the finding to COC who is required to ensure that an incident report is created. SCDHHS monitors the incident report until resolution.

e. Responsibility for Oversight of Critical Incidents and Events. Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

SCDHHS is responsible for overseeing the operation of the incident management system. Critical incidents are entered into the case management system by the waiver provider. SCDHHS will run daily reports to monitor critical incident activity. Incidents will be reviewed by SCDHHS on a monthly basis to determine types of incidents and trends. Information and findings from oversight activities will be communicated quarterly to the Joint Council on Children and Adolescents (JCCA) - Executive Steering Committee or its designee entity. To prevent re-occurrences, SCDHHS will share trend and report data with the Office of the Deputy Children's Advocate and to the South Carolina Law Enforcement Division (SLED)/Child Fatalities Review Office (if a death occurs). Abuse and neglect occurring in therapeutic foster homes during the provision of respite services will be reported to the Out of Home Abuse and Neglect Investigations unit (OHAN).

The county department of social services or to a law enforcement agency in the county where the participant resides or is found responds to the report. See S.C. Code Ann. § 63-7-10 et seq.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. Use of Restraints. *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

◉ **The state does not permit or prohibits the use of restraints**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

The South Carolina Department of Health and Human Services (SCDHHS) and the South Carolina Department of Social Services (SCDSS) conducts yearly licensure reviews for licensed facilities including Therapeutic Foster Care homes. SCDSS, Out of Home Abuse and Neglect Division (OHAN) investigates reports of any abuse or neglect by licensed facilities. Such reports can be made anonymously.

○ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

◉ **The state does not permit or prohibits the use of restrictive interventions**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

1) The South Carolina Department of Social Services (SCDSS) conducts yearly licensure reviews.
2) SCDSS; Out of Home Abuse and Neglect Division (OHAN), investigates reports of any abuse or neglect by licensed facilities. Such reports can be made anonymously.

○ **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

◉ **The state does not permit or prohibits the use of seclusion**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

1. The South Carolina Department of Social Services (SCDSS) - conducts yearly licensure reviews.
2. SCDSS; Out of Home Abuse and Neglect Division (OHAN) - investigates reports of any abuse or neglect by licensed facilities. Such reports can be made anonymously.
3. Referring State Agencies – All child serving state agencies are required to monitor and follow-up at least monthly, with each child they have placed in a licensed facility. Licensed facilities are required to file a Critical Incident (CI) report to the referring state agency within 24 hours from the time of the incident. CIs include any emergency safety intervention.
4. SCDHHS Quality Reviews are conducted annually or as needed. Reviews of respite provided in Therapeutic Foster Care homes will include a review of any use of seclusion reported to be used for children while participating in PCSC Waiver Respite.

○ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

○ **No. This Appendix is not applicable** *(do not complete the remaining items)*

◉ **Yes. This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

There are several measures in place to monitor participant medication management. During the service plan development (SPD) process, the SPD team ensures the appropriateness of the medication regimen. Participant regimens are monitored during each SPD review meeting and each child and family team meeting during waiver enrollment. The Care Management Entity (CME) trains all employees on psychopharmacology as part of their initial on-boarding training. The wraparound facilitator and participant/family team members monitor the participants response to medication changes in all domains. The CME contracts with a board-certified psychiatrist to review and consult (as needed) concerning medications.

Participant medications are monitored through the case management system. Any medication requiring frequent dosage adjustments, regulation or monitoring is identified with a "flag." When psychotropic medications are prescribed, the participant is closely monitored by the child and family team in the manner described above. If respite services are authorized for the participant, the respite provider must also adhere to its agency licensing requirements for medication monitoring and administration. Per the waiver provider enrollment process, only providers meeting the credentialing standards for medication administration will be authorized to provide respite services to participants. Participant psychotropic medication use is monitored by Continuum of Care (COC) monthly. Trend data will be captured and analyzed annually during the quality review.

Monitoring of medication for waiver participants who live in Therapeutic Foster Care (TFC) placements is done by the South Carolina Department of Social Services (SCDSS) as part of the annual licensure renewal.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

The South Carolina Department of Social Services (SCDSS) is responsible for licensing foster homes. As a part of the licensing process and as part of ongoing relicensing reviews, residential providers must have policies and procedures, safety mechanisms, training, and internal quality assurance oversight of their program's medication regime.

On a monthly basis, SCDHHS will examine all SPD reviews conducted the preceding month to monitor medication management and follow-up activities undertaken by the SPD team. Strategies to remediate potentially harmful practices will be communicated to the CME and monitored by SCDHHS. Policy and procedure changes may be initiated. Medication management and administration for participants receiving respite will also be monitored by the credentialing or licensing body of the respite provider or agency. Substance use disorder residential facilities, non-IMD group homes, home health agencies and supportive housing agencies are licensed by the South Carolina Department of Health and Environmental Control (DHEC). Public or private child-serving entities and therapeutic foster homes are licensed by SCDSS. All provider qualifications are verified annually or more frequently based on service monitoring concerns.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

- ○ **Not applicable.** *(do not complete the remaining items)*
- ◉ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. State Policy. Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the

operating agency (if applicable).

For respite provided in the participant home, medication may be administered during respite hours by the respite worker. Medications, including controlled substances, medical supplies, and those items necessary for the rendering of first aid shall be properly managed in accordance with State, Federal, and local laws and regulations. Such management shall address the securing, storing, and administering of medications, medical supplies, first aid supplies, and biologicals, their disposal when discontinued or expired, and their disposition at discharge of a participant.

The administration of medication can be performed by licensed medical personnel and non-medical waiver provider personnel. However, for the short-term respite service, medication cannot be administered during respite hours in the participants home by the respite worker. Therapeutic Foster Care (TFC) parents are an example of non-medical personnel permitted to administer medications. TFC homes are licensed by DSS. TFC parents require training in medication administration, side effects/interactions and proper storage of medications; documentation of medications (time, dosage, frequency), side effects/interactions, medication changes and medication errors; and communication with Service Plan Development review teams and Child and Family Teams.

iii. Medication Error Reporting. *Select one of the following:*

◉ **Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).**
Complete the following three items:

(a) Specify state agency (or agencies) to which errors are reported:

Critical Incidents including medication errors requiring treatment from an outside entity (i.e., Physician's Office, Urgent Care, or Emergency Room) must be reported to the referring state agency (e.g., Continuum of Care, Department of Social Services, or DHSS), within 24 hours from the time of the critical incident.

Staff providing waiver Respite services must be trained on what to do if there is an error in medication administration. If it was an error in documentation, the error should be corrected as required and communicated to the appropriate Supervisor.

If the error was in the administration of the medication such as a missed does or an over dose of medication, the staff should immediately contact a medical professional who can determine what course of action needs to be taken to ensure the safety of the participant. Adverse reactions to med errors must be documented. Med errors must be communicated upon staff change over to ensure continuity of care.

The program policy must include written procedures for documenting and communicating medication error(s). The provider must make every effort to notify all medical personnel who prescribe and/or administer medications to a participant about any medications the participant is currently taking and of any changes in the participants medication since he or she was last seen by the medical provider.

(b) Specify the types of medication errors that providers are required to *record:*

Any error in administering medication that results in the medication given to the participant in a way that it was not intended as prescribed by the clinician.

(c) Specify the types of medication errors that providers must *report* to the state:

Any medication error that results in adverse effects which are detrimental and cause harm to the participants health and safety must be documented in the participants file. Those med errors that result in the need to seek emergency medical attention or contact law enforcement must be reported as a critical incident.

○ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.**

Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

The South Carolina Department of Social Services (SCDSS) is responsible for conducting the initial licensing of foster homes and licensure renewals every two years. As a part of the licensing process, and as part of the on-going re-licensing reviews, residential providers must have policies/procedures, safety mechanisms, training, and internal quality assurance oversight of their program's medication regimen. If a program is found to be out of compliance, SCDSS administers a quality improvement notification. The provider must respond within a certain timeframe with a detailed plan addressing how they will change policies/procedures to address the deficiency.

SCDSS conducts unannounced site visits during this period as well, to ensure appropriate corrective action has taken place and to monitor improvement. In addition, SCDSS has a memorandum of agreement with SCDHHS to ensure the exchange of information between the two agencies related to out-of-home placement services regarding critical incidents or issues that may affect licensure and therefore, Medicaid enrollment, and to establish procedures for coordinating and collaboration between SCDHHS and SCDSS. This procedure applies to medication monitoring and would apply to all participants placed in the waiver. It is the intent of SCDHHS and SCDSS to utilize the shared information to support program maintenance, policy planning and implementation of quality and evidenced based processes for Medicaid provider enrollment and licensing purposes. SCDHHS monitors medications administered annually for waiver participants who receive respite services in Therapeutic Foster Care homes. SCDHHS utilizes annual quality reviews to evaluate if the child and family team has monitored medication management for participants in the waiver. Annual quality reviews evaluate if the services provided met the expected outcomes concerning medication management.

Referring State Agencies - All child-serving State agencies are required to monitor and follow-up at least monthly with each child they have placed in a licensed out-of-home placement. This monitoring process includes a review of medications and medication administration.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and % of new participants or guardians acknowledging receipt of information on how to report abuse, neglect, exploitation and other reportable incidents. Numerator - number of new participants or guardians who received information on how to report abuse, neglect, exploitation and reportable incidents Denominator - total number of newly enrolled participants during the waiver year

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of wraparound facilitators who have required training in abuse, neglect, exploitation and other reportable incidents Numerator- number of wraparound facilitators who received training in abuse, neglect, exploitation and other reportable incidents Denominator - total number of wraparound facilitators employed during the waiver year

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative**

		Sample Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and % of suspected cases of abuse, neglect and exploitation where recommended actions to protect health and welfare were implemented Numerator - number of suspected cases of abuse, neglect and exploitation where recommended actions to protect health and welfare were implemented Denominator - total number of suspected cases of abuse, neglect and exploitation during the waiver year

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and % of Critical Incidents (CIs) reported in required time frame as specified in state policy, aggregated to include ANE or misappropriation of funds types. Numerator – # of CIs reported in required time frame as specified in state policy aggregated by ANE or misappropriation of funds Denominator – Total # of ANE or misappropriation of funds CIs reported during the waiver year

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or

sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of critical incidents that were monitored by the Critical Incident Specialist (CIS) until appropriate resolution. Numerator - number of critical incidents that were monitored by the CIS until appropriate resolution Denominator - total number of critical incidents during the waiver year

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☒ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of participants with a critical incident (CI) with a prevention plan due to abuse, neglect, exploitation,(ANE) or misappropriation of funds Numerator - number of participants with a CI with a prevention plan due to ANE or misappropriation of funds Denominator - total number of participants with a CI of ANE or misappropriation of funds during the waiver year

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☒ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of participant deaths with a determined need for investigation that were investigated. Numerator - number of participant deaths with a determined need for investigation that were investigated Denominator – total number of participant deaths with a determined need for investigation during the waiver year

Data Source (Select one):

Critical events and incident reports
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other**	☒ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
Specify:	
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of instances of restraint, seclusion or other restrictive intervention with a prevention plan developed as a result of the incident. Numerator - number of prevention plans developed as a result of restraint, seclusion or other restrictive intervention Denominator - total number of instances of restraint, seclusion or other restrictive interventions

Data Source (Select one):
Other
If 'Other' is selected, specify:
Incident reporting module in case mangement system - incident management, generates data, performs reporting, etc.

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☒ **Monthly**	☐ **Less than 100% Review**

☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of participants in need of medication administration with a resulting medication administration plan during the waiver year. Numerator – number of participants in need of medication administration with a resulting medication administration plan Denominator – total number of participants with an identified need of medication administration during the waiver year

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☒ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Other
If 'Other' is selected, specify:
Medication administration entries in the case management system

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☒ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of participants or representatives indicating the participant health care needs are being addressed. Numerator - Number of participants or representatives indicating participant health care needs are met. Denominator – Number of participants or representatives reviewed during the waiver year.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval =

		95% and a +/- 5 percent margin of error
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

When issues are discovered by SCDHHS through formal quality review processes, the responsible party is notified by SCDHHS staff. SCDHHS staff identifies the problem, makes the responsible party aware of the problem, and ensures that they have appropriate information to correct the problem. SCDHHS staff formally issues a statement of deficiency requiring a corrective action plan (CAP). If SCDHHS deems the issue to cause imminent danger to the waiver operations or youth, SCDHHS notifies the responsible party and the responsible party is restricted from conducting waiver related supports and services until the issues are resolved and SCDHHS accepts the CAP. Once written notification is received, the CAP must be submitted within 30 days to SCDHHS. The corrective action plan addresses both immediate problems and identifies how the problems will be avoided in the future. SCDHHS reviews corrective action plans to ensure that they address the underlying issues. Failure to submit and implement a corrective action plan may result in being excluded from Medicaid.

When issues are discovered by SCDHHS through informal processes, the responsible party is contacted by SCDHHS staff. SCDHHS staff identifies the problem, makes the responsible party aware of the problem and ensures that they have appropriate information to correct the problem. If SCDHHS deems the issue to cause imminent danger to the waiver operations or youth, SCDHHS issues a formal notice of deficiency and notifies the responsible party. If the issue is of a less serious nature, SCDHHS staff documents the contact and the request for correction to ensure that there is timely and appropriate follow up. The responsible party is given an opportunity to correct the problem informally and submit corrections to SCDHHS staff. If the problem is not addressed in a timely way, SCDHHS staff formally issue a statement of deficiency requiring a corrective action plan. Once written notification is received, the CAP must be submitted within 30 days to SCDHHS. The corrective action plan addresses both immediate problems and identifies how the problems will be avoided in the future. SCDHHS reviews corrective action plans to ensure that they address the underlying issues. Failure to submit and implement a corrective action plan may result in being excluded from Medicaid.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

- (●) **No**
- ( ) **Yes**

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix H: Quality Improvement Strategy (1 of 3)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may

provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The PCSC waiver quality management strategy identifies positive and negative trends to allow for necessary adjustments to enhance performance of the system. Trends identified through the Quality Improvement Strategy will allow South Carolina to make system design changes to better meet the needs of the participant in the waiver, address unforeseen conflicts of interest, improve the quality of services being provided to waiver participants, and make adjustments to our quality improvement process to better evaluate provider compliance.

Quality reviews allow the opportunity to evaluate aggregated waiver data. This supports the State to take necessary actions to address areas of concern, improve systems, and enhance outcomes for youth in the waiver.

SCDHHS is continuously reviewing and updating its Quality Management System processes to ensure it is responsive to the quality assurances. SCDHHS has developed formal processes and activities in this waiver to review the quality of the services provided. These activities use a standard protocol to evaluate each provider and service area consistently. These protocols allow SCDHHS to identify trends, prioritize, and implement system improvements as needed. System improvement activities are designed to ensure that based on the performance measures, all six CMS assurances are addressed (i.e. freedom of choice; initial and annual level of care evaluations; continued eligibility; health and safety; service provision and utilization; person-centered plan development; staff qualifications and training; provider compliance with administrative requirements and; continued monitoring of cost neutrality).

Information collected during these reviews is analyzed and utilized to implement improvements within the program. Prioritizing and implementing system improvements is based on the severity of identified problems and the frequency of duplicated errors. Waiver assurances that are below 100% and issues that the data shows are a statewide trend are top priority and would result in immediate action to improve the system. Systems Improvement for waiver assurances below 100% may involve the following: 1. Revisions to the training program 2. Revision of policy and procedure for clarification 3. Modifications to improve the review process and data collection.

Statewide problems, even if the issue discovered is not one of the six assurances, becomes a top priority based on the prevalence of the problem. Systems improvement for statewide trends can be addressed through any of the following: 1. Revisions to the training program 2. Revision of policy and procedure for clarification 3. Modifications to improve the review process and data collection.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Quality Improvement Committee**	☒ **Annually**
☐ **Other** Specify:	☒ **Other** Specify: As Needed.

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

The following process is used to monitor and analyze data and system design. SCDHHS waiver staff receives the person-centered plan, authorizations and level of care (LOC) for each participant enrolled in the waiver on a quarterly basis. Prior to SCDHHS authorizing services, the person-centered plan, and the LOC are reviewed by SCDHHS waiver staff to ensure quality and compliance with rules, regulations and waiver standards. Services are not authorized by SCDHHS until established standards are met. To ensure that all person-centered plans and levels of care are completed timely as required, a report is generated each quarter to show which person-centered plans and levels of care are past due or due soon. Providers are contacted immediately upon the discovery of a person-centered plan or LOC being found to be out of compliance. A request is made for these documents, and if they are not submitted within a reasonable time frame, a formal request letter is sent to the provider requesting the documents and a corrective action plan.

Offsite administrative reviews are completed in conjunction with an onsite program review for each provider on an annual basis. Providers are required to provide a list of all staff who have provided PCSC waiver services prior to the administrative review so in review of records it can be determined if all staff members have met the requirements for the job they are performing. A service utilization report is generated prior to the onsite review so paid claims can be evaluated based on the performance measures.

The offsite review focuses on administrative requirements such as staff credentials, staff qualifications, staff training, employee screenings, employee background checks, other provider organization requirements and physical location requirements.

The onsite review focuses on service provision requirements such as service delivery in accordance with the person-centered plan, budget and authorizations for services; billable and appropriate service activities, continued eligibility for services; health and safety; cost neutrality.

Unless otherwise noted in the Performance Measures in this waiver, the annual review, conducted by SCDHHS waiver staff, analyzes a 100% sample. The annual review looks at documentation to support services provided within a specified time frame for each provider in each service area in regard to the performance measures established. If previous quarterly reviews or annual reviews have shown a provider to have been out of compliance, the sample may be expanded to ensure that the issues previously discovered have been addressed. If a major concern is discovered during the course of the annual review the sample size and scope of the review may be expanded. Any concerns identified by the standard review protocol are identified and reported to the provider. Any issues that are contradictory to the CMS assurances are communicated at the time of the review; result in immediate action to correct the problem and require the provider to submit a Correction Action Plan to ensure that the problem does not reoccur. An annual review can be initiated at any time that a concern in raised. Any discovery of possible fraud is reported to program integrity.

A report compiling all of these pieces of information is created for each provider when the reviews are completed. Providers are given the report upon its completion. If significant issues are identified, the provider is asked to submit a Corrective Action Plan to address the concerns discovered.

When a full cycle of provider reviews has been completed, an annual report is developed by SCDHHS PCSC waiver staff. This report encompasses all the providers and identifies trends and needed system improvements. SCDHHS evaluates the findings in this report and makes necessary changes and improvements to the waiver.

Problems, issues or concerns that have been identified as a result of the quality improvement activities are addressed through policy change or revision; training; and modifications/changes to the data collection process. If the issues are discovered during annual reviews or during quarterly reviews, on the spot re-education of youth providers occurs to ensure that the provider has the information they need stay in compliance. In addition, trends that become evident prior to a full cycle of reviews being completed are addressed as soon as possible as appropriate. In these cases, the policy is reviewed to determine if clarification might be needed. Exploration into the quality improvement system itself is also analyzed to determine if the approach needs to be adjusted.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The quality improvement strategy is evaluated annually. Based on results of the annual global report, the quality improvement strategy is evaluated to ensure its effectiveness. When the results of the report indicate that changes are needed in the quality improvement strategy, SCDHHS collaborates with necessary parties to address the concerns and improve upon the strategy. In addition, anytime in the review cycle when it is discovered that the quality improvement strategy needs changed, the issue is evaluated and discussed by SCDHHS to adjust it as necessary. One way to discover areas that are not being fully addressed by the quality improvement strategy that we have utilized in the past and will continue to utilize going forward, is seeking out feedback from the youth, families, peer navigators (if applicable, providers, state agencies, and other stakeholders. In this way we get experience, advocacy and data to back up the feedback which allows South Carolina to make sound and appropriate adjustments to the quality improvement strategy.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months *(Select one):*

- (●) **No**
- ( ) **Yes** *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

- ( ) **HCBS CAHPS Survey :**
- ( ) **NCI Survey :**
- ( ) **NCI AD Survey :**
- ( ) **Other** *(Please provide a description of the survey tool used):*

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. *Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).*

Under the Single Audit Act, the SCDHHS is required to secure an independent audit of the entirety of its programs through the State Auditor's office as part of the Single Audit Act. The most recent SCDHHS audit can be found at: http://osa.sc.gov/Reports/stateengagements/Documents/YearEnded2016/J0216.pdf

SCDHHS PCSC waiver staff conducts annual administrative and program reviews to evaluate the quality of the services and ensure that providers are complying with PCSC waiver Policies and Procedures.

In addition, SCDHHS also conducts quarterly reviews of the person-centered plan for each waiver participant with 100% of plans being reviewed annually. When issues of concern are discovered on-site regarding insufficient documentation to bill for services an attempt is made to obtain supporting documentation from the provider. Special reviews are conducted as needed when issues of concern arise. If the provider cannot produce the supporting documentation within a reasonable time frame, SCDHHS waiver Staff contact SCDHHS Program Integrity and refer the concern to them for further investigation.

SCDHHS will annually analyze 100% of paid claims in a desk review in regard to service utilization and cost. When issues or concerning trends are discovered during the course of their research, those issues are reported to SCDHHS waiver staff for further evaluation and investigation into the concern. If SCDHHS's evaluation of the situation determines that claims may have been inappropriate or excessive billings SCDHHS waiver staff contact Program Integrity for further investigation.

In general, the audit review entails the review of applicable program policy, review of paid and/or rejected claims information, and review of the service plan and associated documents filed in support of the claim submission.

The Division of Program Integrity at SCDHHS responds to complaints and allegations of inappropriate or excessive billings by Medicaid providers, and also collects data and analyzes providers in order to identify billing exceptions and deviations. In this capacity, Program Integrity may audit payments to PCSC waiver service providers. Issues that involve fraudulent billing by providers are turned over to the Medicaid Fraud Control Unit in the South Carolina Attorney General's Office. In addition, the Division of Audits reviews SCDHHS contracts with external entities in order to ensure that contract terms are met and only allowable costs are charged. SCDHHS does not require HCBS providers under this waiver to have an independent financial statement audit performed.

SC conducts Program Integrity audits in the following manner in order to protect against fraudulent activity and to ensure fiscal integrity:

- *Provider research is conducted. Research of the provider may include one or more of the following Identification of NPI and affiliations, Secretary of State, Background Checks, MMIS Provider Enrollment Information, Review of Contract and/or Provider Enrollment Records;*
- *The Division of Program Integrity employs the use of investigators to conduct interviews of providers, complainants and beneficiaries. Targeted BEOMBs are also employed to survey a random sample, or all of a particular provider's beneficiary base for confirmation of services rendered.*
- *Applicable Program Policies are identified and reviewed.*
- *Claims research is conducted by the assigned Program Integrity Reviewer and/or Surveillance Utilization Staff.*
- *A review time period is established.*
- *A random sample of claims is conducted as well as additional exception items of interest.*
- *The reviewer initiates a request for provider records. Upon receipt those records are reviewed by the Program Integrity Reviewer to ensure that the documentation clearly indicates the medical need for the services.*
- *After the initial review is completed, a findings letter is generated and supported with pertinent data and analysis reports. The provider is given 10 days to respond and provided an opportunity to request an informal conference to discuss the review findings.*
- *After the 10 day letter, a final determination letter is generated which includes appeal rights, instructions for filing an appeal and the timeframe for which to file an appeal.*
- *If there is an indication of fraudulent billing at any point in the review process, the case is referred to the MFCU.*
- *Regularly scheduled communication and feedback will continue between PI and MFCU until a determination and/or convictions or fraud of civil action is final.*
- *In situations where a credible allegation of fraud exists, PI must suspend the provider's payments and issue appropriate notifications as established by Program Integrity Policies and Procedures.*
- *If the provider fails to abide by the PI recoupment, the provider may be subject to Termination for Cause due to non-payment of a PI established recoupment.*

Once billing exceptions and deviations are identified, the following steps are followed:

- *A review time-period is selected and a random sample is generated. In addition to the random sample selection,*

additional records may be selected from exceptions and deviations discovered on SUR reports.

- *Reviewer requests and review records. Program Integrity may conduct any one of the following types of review:*

o Desk Review - A Desk Review occurs when the Program Integrity Reviewer requests the provider records but does not conduct an on-site review at the provider's place of business.

o Onsite – An onsite occurs whenever there are strong indicators for waste, fraud and abuse.

o Provider Self Review – In a provider self-review the provider performs a self-review and notifies the SCDHHS of the results.

o U-Owe-Us – Data profile and analysis that can be used for provider notification and recoupment. This type of review does not typically require evaluation of the medical record. The provider is provided the opportunity to conduct his/her own review and submit information that may result in revision of the original amount identified by Program Integrity.

- *A review may occur upon receipt of a valid complaint from any source and/or selection as a result of Surveillance Utilization Exception Reporting.*
- *After an overpayment is identified, PI contacts the Fiscal Operations to initiate collection activities to recoup erroneous payment(s). Fiscal Operations contacts the provider to recover the overpayment and/or set up a payment plan, if appropriate. If the provider misses two consecutive payments, Fiscal refers the matter back to PI to begin termination proceedings based on non-payment of a recoupment identified by a Program Integrity review.*

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Financial Accountability Assurance:

The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

i. Sub-Assurances:

a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.

(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of claims for authorized waiver services submitted with the correct service code Numerator: Number of claims submitted with the correct service code Denominator: Total number claims during the waiver year

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Case management system, SAS

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☒ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☐ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☐ ***Representative Sample*** *Confidence Interval =*
☐ ***Other*** *Specify:*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Source *(Select one):*
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☒ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☐ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☐ ***Representative Sample***

		Confidence Interval =
☐ ***Other*** *Specify:*	☐ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☒ ***Other*** *Specify:* *As needed*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

Performance Measure:
Number and percent of HCBS claims verified through the claims compliance audit to have paid in accordance with the participant's waiver plan of care during the waiver

year. Numerator – number of HCBS claims verified during the waiver year Denominator – total HCBS claims reviewed during the waiver year

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Case management system, SAS

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☒ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☐ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☐ ***Representative Sample*** *Confidence Interval =*
☐ ***Other*** *Specify:*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Source *(Select one):*
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid***	☐ ***Weekly***	☒ ***100% Review***

Agency		
☐ ***Operating Agency***	☐ ***Monthly***	☐ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☐ ***Representative Sample*** *Confidence Interval =*
☐ ***Other*** *Specify:*	☐ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☒ ***Other*** *Specify:* *As needed*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*

Performance Measure:
Percent of claims paid for participants who were eligible for services and when the services were provided by a qualified provider during the waiver year. Numerator – number of HCBS clams paid for participants who were eligible for services and when services were provided by a qualified provider during the waiver year Denominator – total number of HCBS claims reviewed during the waiver year

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Case management system, SAS

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☒ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☐ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☐ ***Representative Sample*** *Confidence Interval =*
☐ ***Other*** *Specify:*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Source *(Select one):*
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☒ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☐ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☐ ***Representative Sample*** *Confidence Interval =*
☐ ***Other*** *Specify:*	☐ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☒ ***Other*** *Specify:* *As needed*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☒ ***Annually***

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

Performance Measure:
Number and percent of providers lacking proper supporting documentation with corrected documentation during the waiver year. Numerator – Number of providers lacking proper supporting documentation with corrected documentation during the waiver year Denominator – Total number of providers who lacked proper documentation during the waiver year

Data Source *(Select one):*
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☒ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☐ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☐ ***Representative Sample*** *Confidence Interval =*
☐ ***Other*** *Specify:*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*

	☐ ***Other*** *Specify:*	

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Case management system, SAS

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☒ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☐ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☐ ***Representative Sample*** *Confidence Interval =*
☐ ***Other*** *Specify:*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☒ ***Other*** *Specify:* *As needed*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of waiver claims submitted with the correct rate as specified in the waiver application Numerator: Number of claims submitted with the correct rate Denominator: Total number of claims during the waiver year

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Case management system,SAS

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☒ ***100% Review***

☐ ***Operating Agency***	☐ ***Monthly***	☐ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☐ ***Representative Sample*** *Confidence Interval =*
☐ ***Other*** *Specify:*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*

ii. *If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.*

b. Methods for Remediation/Fixing Individual Problems

i. *Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.*

When issues/problems/concerns are discovered by SCDHHS through formal quality review processes, the responsible party is notified by SCDHHS staff. SCDHHS staff identifies the problem, makes the responsible party aware of the problem, and ensures that they have appropriate information to correct the problem. SCDHHS staff formally issues a statement of deficiency requiring a corrective action plan (CAP). If SCDHHS deems the problem/issue/concern to cause imminent danger to the waiver operations or participant, SCDHHS notifies the responsible party and the responsible party is restricted from conducting waiver related supports and services until the issues are resolved and SCDHHS accepts the CAP. Once written notification is received, the CAP must be submitted within 30 days to SCDHHS. The corrective action plan addresses both immediate problems and identifies how the problems will be avoided in the future. SCDHHS reviews corrective action plans to ensure that they address the underlying issues/concerns. Failure to submit and implement a corrective action plan may result in being excluded from Medicaid.

When issues/problems/concerns are discovered by SCDHHS through informal processes, the responsible party is contacted by SCDHHS staff. SCDHHS staff identifies the problem, makes the responsible party aware of the problem, and ensures that they have appropriate information to correct the problem. If SCDHHS deems the problem/issue/concern to cause imminent danger to the waiver operations or youth, SCDHHS issues a formal notice of deficiency and notifies the responsible party. If the issue/problem/concern is of a less serious nature, SCDHHS staff documents the contact and the request for correction to ensure that there is timely and appropriate follow-up. The responsible party is given an opportunity to correct the problem informally and submit corrections to SCDHHS staff. If the problem is not addressed in a timely way, SCDHHS staff formally issue a statement of deficiency requiring a corrective action plan. Once written notification is received, the CAP must be submitted within 30 days to SCDHHS. The corrective action plan addresses both immediate problems and identifies how the problems will be avoided in the future. SCDHHS reviews corrective action plans to ensure that they address the underlying issues/concerns. Failure to submit and implement a corrective action plan may result in being excluded from Medicaid.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	***Frequency of data aggregation and analysis*** *(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☒ ***Annually***

Responsible Party*(check each that applies):*	***Frequency of data aggregation and analysis*** *(check each that applies):*
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

◉ ***No***

○ ***Yes***

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. *In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).*

The SCDHHS, Bureau of Reimbursement Methodology and Policy, is responsible for the development of waiver service payment rates. The SCDHHS allows the public to offer comments on waiver rate changes and rate setting methodology either through Medical Care Advisory Committee meetings, public hearings, or through meetings with association representatives.

Waiver service rates are established based upon the projected costs of the service to be provided. SCDHHS, Bureau of Reimbursement Methodology perform financial reviews to ensure that funding provided by the South Carolina General Assembly was appropriately expended by providers of these services.

Except as otherwise noted in the State Plan, the State-developed fee schedule is the same for both governmental and private providers and the fee schedule and any annual/periodic adjustments to the fee schedule are published on the State's website at: https://www.scdhhs.gov/resource/fee-schedules.

Fee schedule rates for all services except Individual Directed Goods and Services were developed using a market-based pricing approach. This methodology includes a review of the service definitions, applicable South Carolina regulations, provider qualifications and licensure requirements, required training and certification, staffing requirements and discussions regarding the vision and expectations for service delivery. Allowable cost components were identified to reflect costs that are reasonable, necessary and related to the delivery of service under the 1915(c) waiver. Market-based research was performed to inform the development of the assumptions for the various cost components, along with discussions regarding the State's expectations of service delivery, and these assumptions were then used to model rates for each service. The Bureau of Labor Statistics was the primary data source utilized. Actual provider costs were not used in the development of the fee schedule rates or the development of the modeling assumptions.

We have provided more detail below on the sources reviewed, cost components considered and assumptions used to develop the fees for the 1915(c) waiver services. A market-based pricing approach was used to develop the fees for the waiver services. The State compared the fees developed under the market-based approach to fees in place for similar services in the former CHANCE waiver and other states.

High Fidelity Wraparound (HFW) uses a monthly unit of service. It is delivered by an unlicensed bachelor's level professional with a supervisor who has a bachelor's or master's degree. HFW is an evidence-based practice requiring extensive training, certification and on-going monitoring. While there are no tiered rates, the evidence-based services reflect higher costs of providing the services in fidelity with the national practices including certification, more extensive training, lower caseloads, more travel, and higher provider qualifications. Practitioners, on average, are expected to travel 50 miles a day.

- Respite uses a 15 minute and per diem unit of service as outlined in Appendix C.

The state compared the fees developed under the market-based approach to fees in lace for similar services in the former CHANCE waiver and other states.

The following list outlines the major components of the market-based approached and assumptions modeled in the fee schedule development process. The detailed assumptions are considered confidential and for internal use only by SCDHHS.

- *Direct expenses – Direct care salary expenses were taken from Bureau of Labor Statistics (BLS) wage survey for the type of staff required to deliver the services as indicated in the service definitions. The positions vary by service, but generally include counselors, home care aides, psychologists, social workers, and social and/or human service assistants. The hourly salary assumptions ranged from $9 to $52 per hour based on the service and applicable education requirements.*
- *Employee Related Expenses (ERE) –This category includes ERE the provider is responsible for on behalf of the staff hired to deliver, or oversee the delivery of, the waiver services. This includes items such as the employer's portion of health insurance, worker's compensation, employer taxes (FUTA/SUTA and FICA), disability insurance and paid time off. These assumptions were based on market research from publically available sources such as BLS as well as discussions with SCDHHS.*
- *Program-Related expenses – This category includes salary expense for supervisory staff or other program specialists as defined by the service. It also includes expenditures incurred by the provider through the delivery of the service that are not directly billable. This methodology includes consideration for employee training and certification, staff travel and supply costs, as required by service.*

• *Non-Benefit expenses – This category includes consideration for general administrative expenses such as administrative staff salaries, administrative building costs, insurance and IT needs. This assumption was established at 10% of overall costs for all services.*
• *Productivity – These assumptions were built based on productivity expectations for staff delivering the service. The productivity assumption was 7.0 hours per day for respite.*

A unit of service is defined according to the Healthcare Common Procedure Coding System (HCPCS) approved code set consistent with the National Correct Coding Initiative.

While there are no tiered rates, the High Fidelity Wraparound service reflects the higher costs of providing the service in fidelity with the national practices including certification, more extensive training, lower caseloads, more travel, and higher provider qualifications.

Individual directed goods and services are the only self-directed services and there is not an agency directed model of these services so there is no difference in rate setting. These services are reimbursed based on the price paid by the consumer/FMS entity for the service (i.e., the price of the good).

Goods and services are reimbursed based on the price paid by the participant/FMS entity for the good or service being purchased. The participant has budget authority for this self-directed service and may choose the amount paid for the goods and services under this authority. The participant is the employer of record for any individuals employed or selecting any vendor providing goods. There is a $2,000 lifetime limit per participant as noted in Appendix C under the Individualized Directed Goods and Services (IDGS) limits on the amount, frequency, or duration of this service. The maximum is based upon limits in the PRTF CHANCE waiver ($1,940) and other states for similar goods and services (e.g., New York has a $2,000 limit for the same good and service). IDGS are only paid for by the FMS entity once the goods or services are verified as received, the goods and services are on the approved service plan, and that the expenditures do not exceed the lifetime limit. For additional information see Appendix E-2 Budget Authority and Expenditure Safeguards.

The waiver service rates are not updated annually. The State will monitor rate sufficiency using the following techniques and amend the waiver if a rate methodology change is warranted.

To monitor for rate sufficiency, the following approaches will be taken under the future waiver period with each waiver renewal; any time an access complaint is received from a provider or beneficiary; or if there is a lack of provider capacity for a service needed by a child:
o Analyze and incorporate feedback from stakeholders. This approach includes evaluating feedback from individuals, families, independent case managers, advocacy groups and providers about the adequacy of direct service providers and collecting data on fair hearings, complaints and grievances related to lack of providers.
o Collect evidence from QIS D, sub-assurance d – This approach includes review of evidence related to the performance measures outlined in QIS D, sub-assurance d, which reviews whether services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the person-centered plan. This evidence includes the specific performance measure that assess whether services are delivered as outlined in the service plans by qualified individuals. The review starting in year four of the past waiver includes determining the reasons that individuals are not receiving services in accordance with the service plan.
o Measure changes in provider capacity – This approach includes measuring the change in the number of the new providers and these providers' capacity as well as service utilization of enrollees and comparing the capacity and service utilization information to the previous years' data.

Rate Determination Methods
• *The State notes that all rates, except for individual goods and services, were developed using a market-based pricing approach. However, the State does not provide the payment or methodology for individual goods and services. Update Appendix I-2-a to include the rate methodology for individual goods and services. What payment parameters apply to individual goods and services? Does this service have a maximum rate? If so, specify and provide an explanation for how this maximum rate was established. Goods and services are reimbursed based on the price paid by the participant/FMS entity for the good or service being purchased. The participant has budget authority for this self-directed service and may choose the amount paid for the goods and services under this authority. The participant is the employer of record for any individuals employed or selecting any vendor providing goods. There is a $2,000 lifetime limit per participant as noted in Appendix C under the Individualized Directed Goods and Services (IDGS) limits on the amount, frequency, or*

duration of this service. The maximum is based upon limits in the PRTF CHANCE waiver ($1,940) and other states for similar goods and services (e.g., New York has a $2,000 limit for the same good and service). IDGS are only paid for by the FMS entity once the goods or services are verified as received, the goods and services are on the approved service plan, and that the expenditures do not exceed the lifetime limit. For additional information see Appendix E-2 Budget Authority and Expenditure Safeguards.

b. Flow of Billings. *Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:*

Provider billings flow directly from providers to the State's claim payment system. Providers may bill either by use of a CMS form 1500 or by the State's electronic billing system.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one):*

- ◉ ***No. state or local government agencies do not certify expenditures for waiver services.***
- ○ ***Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.***

Select at least one:

☐ ***Certified Public Expenditures (CPE) of State Public Agencies.***

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).(Indicate source of revenue for CPEs in Item I-4-a.)

☐ ***Certified Public Expenditures (CPE) of Local Government Agencies.***

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. *Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:*

Upon submission of a claim to MMIS, payment is made to the provider only if the participant was Medicaid eligible on the date of service and there was an indicator in MMIS that the participant is enrolled in the waiver program. The Division of Program Integrity conducts post-payment reviews. These reviews sample claims and determine if services have been billed as authorized and are included in the participant service plans.

e. Billing and Claims Record Maintenance Requirement. *Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.*

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS *(select one):*

- (●) ***Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).***
- ( ) ***Payments for some, but not all, waiver services are made through an approved MMIS.***

  Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ( ) ***Payments for waiver services are not made through an approved MMIS.***

  Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ( ) ***Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.***

  Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. *In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):*

- ☐ ***The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.***

☒ ***The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.***

☐ ***The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.***

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

☐ ***Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.***

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. *Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:*

◉ ***No. The state does not make supplemental or enhanced payments for waiver services.***

○ ***Yes. The state makes supplemental or enhanced payments for waiver services.***

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. *Specify whether state or local government providers receive payment for the provision of waiver services.*

○ ***No. State or local government providers do not receive payment for waiver services.*** *Do not complete Item I-3-e.*

◉ ***Yes. State or local government providers receive payment for waiver services.*** *Complete Item I-3-e.*

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

State agency providers of behavioral health service are eligible to provide all waiver services if they meet pertinent provider qualifications. All waiver services have open enrollment, and both public and private providers who are qualified can enroll.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

- ◉ ***The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.***
- ○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.***
- ○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.***

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. *Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:*

- ◉ ***Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.***
- ○ ***Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.***

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

◉ ***No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.***

○ ***Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).***

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

◉ ***No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.***

○ ***Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.***

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs.

◉ ***The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.***

○ ***The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.***

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

○ ***This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.***

○ ***This waiver is a part of a concurrent ?1115/?1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The ?1115 waiver specifies the types of health plans that are used and how payments to these***

plans are made.

○ ***If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.***

In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:*

☒ ***Appropriation of State Tax Revenues to the State Medicaid agency***

☐ ***Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.***

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

☐ ***Other State Level Source(s) of Funds.***

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:*

◉ ***Not Applicable****. There are no local government level sources of funds utilized as the non-federal share.*

○ ***Applicable***

Check each that applies:

☐ ***Appropriation of Local Government Revenues.***

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ ***Other Local Government Level Source(s) of Funds.***

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. *Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:*

◉ ***None of the specified sources of funds contribute to the non-federal share of computable waiver costs***

○ ***The following source(s) are used***

Check each that applies:

☐ ***Health care-related taxes or fees***

☐ ***Provider-related donations***

☐ ***Federal funds***

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

○ ***No services under this waiver are furnished in residential settings other than the private residence of the individual.***

◉ ***As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.***

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. *The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:*

Respite service may be offered in a foster care home, provided the foster home meets all qualifications and is enrolled as a respite provider. Foster home room and board is paid with 100% State dollars. These funds are located in a separate account that can only be accessed through the use of appropriate edit codes.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- ◉ ***No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.***
- ○ ***Yes. Per 42 CFR §441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.***

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. *Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:*

- ◉ ***No. The state does not impose a co-payment or similar charge upon participants for waiver services.***
- ○ ***Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.***

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- ☐ ***Nominal deductible***
- ☐ ***Coinsurance***
- ☐ ***Co-Payment***
- ☐ ***Other charge***

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. *Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:*

- ◉ ***No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.***
- ○ ***Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.***

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. *Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.*

Level(s) of Care: Hospital

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	11878.14	45713.00	57591.14	11941.00	97933.00	109874.00	52282.86
2	12300.00	46624.00	58924.00	12180.00	99892.00	112072.00	53148.00
3	11902.31	47557.00	59459.31	12423.00	101890.00	114313.00	54853.69
4	11914.39	48508.00	60422.39	12672.00	103927.00	116599.00	56176.61
5	11926.48	49478.00	61404.48	12925.00	106006.00	118931.00	57526.52

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. *Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:*

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		Hospital
Year 1	240	240
Year 2	290	290
Year 3	360	360
Year 4	420	420
Year 5	480	480

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. *Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.*

280 days or 40 weeks – This is based upon the Average Length of Stay from the State's former CHANCE PRTF 1915(c) waiver.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. *Provide a narrative description for the derivation of the estimates of the following factors.*

i. Factor D Derivation. *The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:*

Factor D was derived based on the fee schedule developed for services covered under this waiver, along with assumptions about number of users for each service, as well as the utilization for the average user of each service.

The initial unduplicated number of participants in the waiver at any given point in time is 200, which was estimated given the capacity of South Carolina to provide High Fidelity Wraparound in compliance with the fidelity standards of the model. Each year, the State anticipates adding the capacity to serve roughly 40 additional individuals at any given time. The source for the participant growth rate is the budget requested to add that capacity for HFW in SC and the ability of the state to ramp up capacity in a timely, but high-quality manner.

The utilization projections were based on experience in the CHANCE waiver that offered similar services, as well as experiences in other states' waiver programs when similar services were added to their array of waiver services:

- *100% of individuals are expected to receive case management services;*
- *from the CHANCE waiver ;*
- *Respite utilization is based upon the historic South Carolina CHANCE waiver;*

Factor D estimates also reflect expected impacts of differences in the new PCSC waiver and the CHANCE waiver and other similar programs in other states with similar services and populations. Year 1 represents the baseline of the estimates for the Factor D (pricing using Master's rates only).

For Year 2 through Year 5, unit utilization was trended forward using a 2.0% annual inflation factor, using the Mid-Atlantic Consumer Price Index (CPI) inflation factor for similar services from 2012 which the State believes is representative of the projected time periods in the waiver. http://www.bls.gov/regions/mid-atlantic/data/consumerpriceindexhistorical1967base_us_table.htm

After the adjustments were made and utilization determined for each waiver year, the projected Factor D was derived by dividing total service costs each year by the total estimated unduplicated count of waiver participants, as listed in Appendix B-2. The Average Length of Stay of the CHANCE waiver was utilized.

The wraparound service is a structured monthly unit payment and must be capped at 12 monthly units per participant per waiver year. The respite service unit utilization rate was trended forward at 2%. Participants who choose to direct services receive up to $2,000 over the course of the waiver enrollment period. This is a lifetime cap. For these reasons, the 2% annual inflation was not applied to these services.

ii. Factor D' Derivation. *The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor D' is derived from projecting forward the Factor D' costs used in the terminated South Carolina's CHANCE waiver. Costs are projected based on inflation of 2%, which is consistent with available mid-Atlantic CPI estimates that will be applicable to the time period as noted above. This children's population includes only Medicaid coverable costs and excludes the costs of prescribed drugs for individuals eligible for Medicare Part D.

iii. Factor G Derivation. *The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor G is derived from state fiscal year (SFY) 2015 costs related to children with an inpatient admission to a standalone psychiatric hospital with a behavioral health diagnosis. The costs encapsulated in Factor G are for the inpatient costs. Costs are projected based on inflation of 2%, which is consistent with available mid-Atlantic CPI estimates that will be applicable to the time period as noted above. This children's population includes only Medicaid coverable costs and excludes the costs of prescribed drugs for individuals eligible for Medicare Part D.

iv. Factor G' Derivation. *The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor G' is derived from state fiscal year (SFY) 2015 costs related to children with an inpatient admission to a standalone psychiatric hospital with a behavioral health diagnosis. The costs encapsulated in Factor G' are for services other than the inpatient stay(s). G' is greater than D' because the G' includes the costs of stays in psychiatric residential treatment facilities (PRTFs) which can be longer term stays and cost. The costs encapsulated in Factor G are for the inpatient costs. Costs are projected based on inflation of 2%, which is consistent with available mid-Atlantic CPI estimates that will be applicable to the time period as noted above.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. *If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "manage components" to add these components.*

Waiver Services	
High Fidelity Wraparound	
Respite	
Individual Directed Goods and Services	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 1

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
High Fidelity Wraparound Total:							**2224800.00**
High Fidelity Wraparound	☐	Per Month	200	12.00	927.00	**2224800.00**	
Respite Total:							**321954.24**
Respite	☐	15 min	152	275.00	3.18	**132924.00**	
Respite	☐	Per diem	152	14.00	88.83	**189030.24**	
Individual Directed							**304000.00**

GRAND TOTAL:	**2850754.24**
Total: Services included in capitation:	
Total: Services not included in capitation:	2850754.24
Total Estimated Unduplicated Participants:	**240**
Factor D (Divide total by number of participants):	**11878.14**
Services included in capitation:	
Services not included in capitation:	11878.14
Average Length of Stay on the Waiver:	280

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Goods and Services Total:							
Individual Directed Goods and Services	☐	unit	152	1.00	2000.00	**304000.00**	

GRAND TOTAL:	**2850754.24**
Total: Services included in capitation:	
Total: Services not included in capitation:	2850754.24
Total Estimated Unduplicated Participants:	**240**
Factor D (Divide total by number of participants):	**11878.14**
Services included in capitation:	
Services not included in capitation:	11878.14
Average Length of Stay on the Waiver:	280

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 2

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
High Fidelity Wraparound Total:							**2781000.00**
High Fidelity Wraparound	☐	Per Month	250	12.00	927.00	**2781000.00**	
Respite Total:							**406068.00**
Respite	☐	15 min	190	281.00	3.18	**169780.20**	
Respite	☐	Per diem	190	14.00	88.83	**236287.80**	
Individual Directed Goods and Services Total:							**380000.00**

GRAND TOTAL:	**3567068.00**
Total: Services included in capitation:	
Total: Services not included in capitation:	3567068.00
Total Estimated Unduplicated Participants:	**290**
Factor D (Divide total by number of participants):	**12300.00**
Services included in capitation:	
Services not included in capitation:	12300.00
Average Length of Stay on the Waiver:	280

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Individual Directed Goods and Services	☐	unit	190	1.00	2000.00	380000.00	

GRAND TOTAL:	3567068.00
Total: Services included in capitation:	
Total: Services not included in capitation:	3567068.00
Total Estimated Unduplicated Participants:	290
Factor D (Divide total by number of participants):	12300.00
Services included in capitation:	
Services not included in capitation:	12300.00
Average Length of Stay on the Waiver:	280

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 3

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
High Fidelity Wraparound Total:							3337200.00
High Fidelity Wraparound	☐	Per Month	300	12.00	927.00	3337200.00	
Respite Total:							491631.84
Respite	☐	15 min	228	287.00	3.18	208086.48	
Respite	☐	Per diem	228	14.00	88.83	283545.36	
Individual Directed Goods and Services Total:							456000.00
Individual Directed Goods	☐	unit	228	1.00	2000.00	456000.00	

GRAND TOTAL:	4284831.84
Total: Services included in capitation:	
Total: Services not included in capitation:	4284831.84
Total Estimated Unduplicated Participants:	360
Factor D (Divide total by number of participants):	11902.31
Services included in capitation:	
Services not included in capitation:	11902.31
Average Length of Stay on the Waiver:	280

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
and Services							
					GRAND TOTAL:		4284831.84
					Total: Services included in capitation:		
					Total: Services not included in capitation:		4284831.84
					Total Estimated Unduplicated Participants:		360
					Factor D (Divide total by number of participants):		11902.31
					Services included in capitation:		
					Services not included in capitation:		11902.31
					Average Length of Stay on the Waiver:		280

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 4

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
High Fidelity Wraparound Total:							**3893400.00**
High Fidelity Wraparound	☐	Per Month	350	12.00	927.00	**3893400.00**	
Respite Total:							**578645.76**
Respite	☐	15 min	266	293.00	3.18	**247842.84**	
Respite	☐	Per diem	266	14.00	88.83	**330802.92**	
Individual Directed Goods and Services Total:							**532000.00**
Individual Directed Goods and Services	☐	unit	266	1.00	2000.00	**532000.00**	
					GRAND TOTAL:		5004045.76
					Total: Services included in capitation:		
					Total: Services not included in capitation:		5004045.76
					Total Estimated Unduplicated Participants:		420
					Factor D (Divide total by number of participants):		11914.39
					Services included in capitation:		
					Services not included in capitation:		11914.39
					Average Length of Stay on the Waiver:		280

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 5

Waiver Service/ Component	*Capi-tation*	*Unit*	*# Users*	*Avg. Units Per User*	*Avg. Cost/ Unit*	*Component Cost*	*Total Cost*
High Fidelity Wraparound Total:							***4449600.00***
High Fidelity Wraparound	☐	*Per Month*	*400*	*12.00*	*927.00*	***4449600.00***	
Respite Total:							***667109.76***
Respite	☐	*15 min*	*304*	*299.00*	*3.18*	***289049.28***	
Respite	☐	*Per diem*	*304*	*14.00*	*88.83*	***378060.48***	
Individual Directed Goods and Services Total:							***608000.00***
Individual Directed Goods and Services	☐	*unit*	*304*	*1.00*	*2000.00*	***608000.00***	

GRAND TOTAL:		***5724709.76***
Total: Services included in capitation:		
Total: Services not included in capitation:		*5724709.76*
Total Estimated Unduplicated Participants:		***480***
Factor D (Divide total by number of participants):		***11926.48***
Services included in capitation:		
Services not included in capitation:		*11926.48*
Average Length of Stay on the Waiver:	*280*	