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 section 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 waiver's 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:
Medically Complex Children

C. Waiver Number:SC.0675

D. Amendment Number:SC.0675.R03.06

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

10/01/24

Approved Effective Date: 10/01/24
Approved Effective Date of Waiver being Amended: 01/01/22

2. Purpose(s) of Amendment

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

The purpose of this amendment is to add attendant care as a participant-directed service to the waiver program. The addition of attendant care will allow legally responsible individuals (including parents of minor children), relatives and legal guardians to be the paid caregiver when the participant has been assessed to need the service.

The state is not using any funding from section 9817 of the American Rescue Plan Act of 2021 (ARP) for the implementation of changes under this amendment.

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**	

Component of the Approved Waiver	Subsection(s)
☒ Appendix A - Waiver Administration and Operation	A-5, 6
☐ Appendix B - Participant Access and Eligibility	
☒ Appendix C - Participant Services	C-1, 2, QI
☐ Appendix D - Participant Centered Service Planning and Delivery	
☒ Appendix E - Participant Direction of Services	E-1, 2
☐ Appendix F - Participant Rights	
☐ Appendix G - Participant Safeguards	
☐ Appendix H	
☐ Appendix I - Financial Accountability	
☒ Appendix J - Cost-Neutrality Demonstration	J-1, 2

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:

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 section 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*):

Medically Complex Children

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.0675.R03.06
Draft ID: SC.008.03.03

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

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 01/01/22
Approved Effective Date of Waiver being Amended: 01/01/22

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 in 42 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 section 1915(a)(1)(a) of the Act and described in Appendix I**

☐ **Waiver(s) authorized under section 1915(b) of the Act.**

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

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

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

☐ **section 1915(b)(2) (central broker)**

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

☐ **section 1915(b)(4) (selective contracting/limit number of providers)**

☐ **A program operated under section 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 section 1915(i) of the Act.**

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

☐ **A program authorized under section 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.

South Carolina is seeking to renew the Medically Complex Children waiver (MCCW). The Medically Complex Children waiver serves children who meet hospital level of care (LOC), and have chronic physical/health conditions expected to last longer than 12 months. The participants must also meet the State-defined medical eligibility criteria which evaluates the child's dependency on medications, medical supervision, hospitalizations, skilled nursing services, therapies and medical specialists. SCDHHS administers and operates the waiver. Contracted Nurse Care Coordinators are located throughout the entire state and are responsible for ensuring that participants/participant families are aware of their service options and can make informed choices as to which form of service delivery they prefer.

The goal of this waiver is to decrease hospitalizations, emergency room visits and/or enhance the quality of life for participants in a cost-effective manner.

The objective of the waiver is to provide ongoing continuity of care through the provision of a nurse care coordinator who serves as a liaison between the waiver participant and all medical and community service providers. The services offered in this waiver include: Environmental Modification, Pediatric Medical Day Care, Respite, and Nurse Care Coordination. Nurse care coordinators also monitor Medicaid state plan services received by waiver participants.

Description of Phoenix and Electronic Visit Verification System (EVV)
Phoenix is South Carolina’s automated web-based case management system. Components include:

- Demographic information
- Applications for waivers and status of applications
- All assessments conducted, including level of care (LOC) determination
- Person-Centered Service Plans
- Service referrals/authorizations for waiver services
- Documentation of other community supports
- Home assessment component
- Caregiver supports section indicating available supports
- Electronic Visit Verification System (EVV) summary information

Phoenix has a number of features included in the software to ensure compliance with federal requirements. Examples include:

- Not allowing assessments to be conducted on any applicant that fails to meet intake criteria (e.g., does not live in state and has not indicated intent to move)
- Not allowing waiver enrollment to anyone without an appropriate level of care within 30 days of waiver enrollment
- Not allowing any waiver service to be authorized that is not indicated in the service plan
- Flagging and recording all cases where any federal regulations or state policies are not being followed appropriately.

The Electronic Visit Verification (EVV) system includes an Interactive Voice Response System (IVRS) and mobile application used by providers to record service provision. The EVV receives information from Phoenix, such as authorized services, schedule and frequency of authorizations, phone numbers of waiver participants and information about providers and provider workers. The EVV indicates the agency, worker and service being performed and for which waiver participant. This is compared with the service authorization to ensure that claims are made only for authorized services and only up to the authorized amount. The EVV system now also captures the tasks performed and observations by in-home workers. Providers use the Phoenix system to produce reports regarding the provision of service. In addition, claims are now submitted to MMIS for payment by Phoenix daily (except Mondays). This results in a quick turnaround in payments to providers because the claims are always submitted with the correct procedure code, amount, etc.

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 section 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 section 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 section 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 section 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:

Public Input Actions

Public Notice of intent to amend this waiver was posted to the agency website at https://www.scdhhs.gov/public-notices on May 24, 2024. This waiver amendment was posted to the agency website at https://www.scdhhs.gov/service/waiver-management-field-management on May 24, 2024. Hard copies of the waiver amendment were placed in the SMA Central Office lobby and the 13 SMA offices around the state on May 24, 2024 for public review and comments.

A summary of the amendment was presented to the Medical Care Advisory Committee (MCAC) on May 14, 2024.
A summary of the amendment was presented to the Indian Health Organization on February 28, 2024 and April 24, 2024.

Additionally, two public webinars were held on June 14, 2024 and June 18, 2024 respectively, to address the proposed waiver amendment. A recording of the June 18, 2024, webinar was posted to the agency's website at https://www.scdhhs.gov/service/waiver-management-field-management.

Individuals were able to submit electronic comments to comments@scdhhs.gov and non-electronic comments to Office of Waivers and Facility Services, South Carolina Department of Health and Human Services, Post Office Box 8206, Columbia, SC 29202-8206, Attention: Janice Bailiff. Both methods of comment submission were included in all public notices.

A comprehensive summary of public comments received during the comment period and the State's response are included in Main B. Optional section of this waiver application.

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: PO Box 8206

Address 2:

City: Columbia

State: **South Carolina**

Zip: 29202

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:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **South Carolina**

Zip:

Phone:

Ext: **TTY**

Fax:

E-mail:

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 section 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: Sep 13, 2024

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

Last Name: Kerr

First Name: Robert

Title: Agency Head

Agency: South Carolina Department of Health and Human Services

Address: 1801 Main Street

Address 2:

City: Columbia

State: **South Carolina**

Zip: 29201

Phone: (803) 898-2507 **Ext:** **TTY**

Fax:

(803) 255-8209

E-mail:

rkerr@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.

The state assures that this waiver amendment is subject to the provisions and requirements included in the most recent home and community-based settings Statewide Transition Plan.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

A comprehensive summary of public comments received during the comment period and the State's response are included below.

GENERAL WAIVER QUESTIONS/COMMENTS

Q. When will the FAQ document be published?

• A: The FAQ will be made available once all comments and questions have been compiled.

Q: How many children are currently enrolled under the MCC waiver?

• A: 1,834 as of April 2024

Q: Will there be a limit of participants like some of the other waiver plans? This leads to the wait list some of us are currently on.

•A: The MCC waiver program does not maintain a waiting list.

Q: Can there be several attendants for one child? Ex: two parents and Grandma all split the 40 hours.

•A: Yes, there may be several attendant caregivers identified to meet the assessed needs of a participant, but services from each attendant may not be provided at the same time.

Q: Does the complex program work if you go on TEFRA Medicaid?

• A: Yes, children enrolled in the TEFRA Medicaid Program can also be enrolled in the MCCW Program.

Q: So will it automatically start in Oct or do we have to apply like a job after approval?

• A: Yes, individuals interested in becoming an attendant must apply and be approved. Contact your waiver nurse case manager with questions.

Q: Will an email be sent out when it becomes available and we can apply to become our child's attendant?

• A: Your waiver nurse case manager will be your first point of contact for questions. If the waiver amendment is approved, SCDHHS will publish a bulletin with pertinent details.

Q: First I want to say this is a much needed step forward for South Carolina. I can attest personally how hard it is on a family financially and emotionally to have a child with special needs. Most families on this waiver make sacrifices and aren't able to work because they have to offer around the clock care for their child. Due to this and the financial limitations on SSI it seems we are made to either live in poverty to get a little help or either we get help and still have to struggle with day to day finances due to inflation in everything. While the average cost to raise a neurotypical child in 2024 is $25,714 while this number is high and hard to obtain for most if you add in a child with special needs that number increases. In 2024 it estimated that a family with only 1 disabled child should expect to spend 17.8% more to raise that child. With that being said I plan to apply for this for my child if it passes and I have a few questions that were not clearly laid out in the webinar.

• A: SCDHHS thanks you for your comments.

Q: Page 15 of the application states:
Additionally, two public webinars will be held on June 14, 2024 and June 18, 2024 respectively, to address the proposed waiver amendment. A recording of the June 18, 2024, webinar will be posted to the agency's website at https://www.scdhhs.gov/service/waiver-management-field-management.

Q: The recording of this webinar was not made available during the public comment period. Please extend the public comment period to allow the public ample time to comment on this item promised in the public record.

• A: The public comment period was extended. It closed on June 26, 2024.

Q: General: The acronym SMA is not defined in this document. Please define SMA.

• A: SMA is an acronym for State Medicaid Agency.

Q: Will this be interpreted in Spanish for those who do not understand English?

• A: The presentation has been translated in Spanish and is posted on the SCDHHS website.

Q: This amendment will allow for the provisions of parent attendant care, which is a much needed program for our state. Public input is a valuable component of making our state programs both beneficial and effective. After reviewing the amendment, the slides and the recorded webinar, I offer the following additional comments for consideration. Can you please describe who will perform each bullet in slide 12? It is unclear.

•A: The content from slide 12 and the responses to your questions are provided below in parenthesis).

• Assessment to determine need for attendant care service (completed by MCC waiver nurse case manager)

➢ Includes evaluation by licensed professional involved in participant's medical care with specific competencies documented (MCC Waiver nurse case manager requests the completion of the Physician Information form from the child's medical provider).

• Addition of service to waiver service plan by waiver care coordinator (MCC waiver nurse)

• Completion of background screening and documentation of required training (University of South Carolina contracted nurse helps proposed attendant complete these tasks)

• Scheduling and completion of nurse match visit to verify ability to complete identified tasks (University of South Carolina contracted nurse)

Q: Page 62 states: Potential providers are given the opportunity to enroll/contract with the SCDHHS. Potential providers are made aware of the requirements for enrollment through 1) The agency's website and 2) contacting the Medicaid agency directly.

Potential providers are given a packet of information that is used in the enrollment process. Some services specified in this waiver require pre-contractual review and signed contract for enrollment as a provider. When will this be available on the website? When and how will the information packets be distributed?

• A: The enrollment process for self-directed attendant caregivers is separate from the enrollment process for agency-based services. Self-directed attendant caregivers are subject to the attendant care enrollment process. This process is described in greater detail in Appendix E of the waiver document.

Q. Page 100 states: A monthly fee per participant is charged for financial management services. Who pays this monthly fee? How is it assessed? How much is this monthly fee?

• A: SCDHHS contracts with a fiscal management agency to process payments to self-directed attendant caregivers. A monthly fee is paid by SCDHHS to the fiscal management agency for each self-directed attendant caregiver.

CHANGES TO THE WAIVER APPLICATION

Q: Is the feedback you receive here being considered before the change is presented for approval? (i.e. the travel aspect)

• A: Yes, SCDHHS is considering all feedback during this application process.

Q: Can us as parents of these kids on the waiver have an actual say? Often our voices aren't heard, and we get programs that may not fit our needs fully.

• A: Yes, SCDHHS relies on feedback from our parent and provider stakeholders when developing programs. This partnership is critical to ensure the MCC waiver program meets the needs of children with complex needs in South Carolina.

Q: Questions and responses from the February 2023 addendum are contradictory to the May 2024 draft application as page 61 states: Legally responsible individuals including parents of children up to age 21 may receive payment to provide attendant care to waiver participants. Please provide a distinction between earlier comments, the draft application and comments received on the May draft that will be included upon incorporation.

• A: The February 2023 questions and answers were provided in response to the previous waiver amendment to revise the family caregiver policy for waivers with personal care services. The Medically Complex Children waiver included nurse care coordination, respite, pediatric medical day care and environmental modifications. As such these responses did not apply to the MCC waiver program. The current amendment seeks to add self-directed attendant care as a service to the MCC waiver. The amendment also seeks approval to include parents of minor children enrolled in the MCC waiver as a category of individuals permitted to receive payment for rendering extraordinary personal care to a waiver participant. Qualified parents of minor children with extraordinary direct care needs will be eligible to receive payment to provide direct care service in accordance with an approved service plan.

Q. Page 138 states: The Self-Directed Attendant Care rate is determined based upon the salaries of frontline workers of personal care agencies. Their salaries represent a slightly higher rate because there are no benefits provided. […] Attendant Care services are paid at a fixed rate. This rate includes the hourly rate for the service plus the employee and employer share of taxes and other benefits. What are "other benefits" since it states earlier in the paragraph there are no benefits provided?

• A: "The waiver language has been revised to read "The Self-Directed Attendant Care rate is determined based upon the salaries of frontline workers of personal care agencies. Personal Care Aide salaries represent a slightly higher rate because there are no benefits provided. The SMA uses market analysis to determine what the private rate is for Attendant Care services. This research consists of an informal process whereby private providers are contacted to inquire about the private pay rate for the same service. The SMA takes this information into consideration when determining rates or adjustments to rates. As appropriate, the SMA will survey agencies for the salaries of frontline workers. Attendant Care services are paid at a fixed rate. This rate includes the hourly rate for the service plus the employee and employer share of taxes and standard deductions.

Q. Page 149 states: Based on the utilization of Children's Personal Care in SFY 2023 claims data, we have assumed that 40% of the MCC participants will utilize self-directed Attendant Care, effective October 1, 2024 (three quarters of the way through waiver year 3). What is the basis of the 40% assumption? It seems that given the level of parental interest, participation may be underestimated at 40%. Why would the same assumption of 40% be carried through years 4 and 5?

• A: The estimates are based on the actual experience of personal care and nursing utilizations in SFY 2023.

Q. Pages 151-153 show an hourly rate of $18.44 and $19, respectively. Years 3 and 4 show a difference of 12% from the proposed attendant pay rate. Year 5 shows a difference of 15% from the proposed attendant pay rate. What does the 12% provide to the participant or the attendant? Will the attendant receive a 3% pay increase in year five?

• A: There is no payment to the participant. This section of the waiver describes projected costs that must be reasonably estimated and annualized to cover each year of the waiver period. Since these are projections, they do not reflect finalized rates but reflect a trend factor that is applied to project estimated costs.

AMENDMENT APPROVAL

Q: What are the reasons this wouldn't be approved by CMS? Can our care coordinators help us start taking approval steps now, so we are ready in October?

• A: CMS reviews waiver amendment applications to ensure they align with federal regulations. We will know on or after October 1 if the application has been approved.

Q: What is the date that you will know if the state approves this or not?

• A: We will know on or after October 1, 2024, if the application has been approved by CMS, the federal authority that approves waiver amendments.

Q: What steps can we as parents do to support this proposal getting approved?

• A: Continue to maintain contact with your waiver nurse case manager.

PROVIDER QUALIFICATIONS

Q: What if you are already CPR and BLS certified for Healthcare Providers (AHA), and it is current?

• A: If the application is approved, a SCDHHS contracted vendor will review all training certifications and notify potential attendant caregivers if additional training is required.

Q: Is this only for the parents? Or anyone over 18?

• A: If approved, parents of minor children, relatives, legal guardians, family friends, etc. who meet the provider qualifications may serve as the attendant care giver. Self-directed attendant caregivers must be at least 18 years of age and meet all SC Medicaid provider qualifications.

Q: If the parent has guardianship after the child is 18 years old, can they still be the attendant care provider?

• A: Yes, as long as the child is enrolled in the MCC waiver program and all SC Medicaid provider qualifications are met.

Q: Is this open for Foster Parents?

• A: Yes, if approved, parents of minor children, relatives, legal guardians, family friends, etc. who meet the provider qualifications may serve as the attendant care giver. Parents include foster parents and stepparents.

Q: Can we opt for the QuantiFERON gold test instead? I get that done annually for school.

• A: A state approved tuberculin skin test will be required. The Quantiferon Gold test is acceptable.

Q: It sounds like the assessment for our kids is what we've already done and won't likely gain more hours if our children's health hasn't changed.

• A: That is correct. The attendant care service is based upon the assessed need of the child.

Q: Can the attendant and responsible party for the waiver be the same individual?

• A: For the MCCW Program, the attendant may be the responsible party.

Q: Hello, if we are under an agency and I have a nurse in the home, will they be able to check me off as competent so that I can receive these additional services?

• A: The University of South Carolina contracted nurse will work with the MCCW nurse case manager to ensure the attendant caregiver(s) is fully trained. The contract nurse will conduct a match visit with the family to ensure self-directed attendant care is a positive, viable option for the child and family.

Q: If the parent gets approved and has to undergo surgery will their “employment” be put on hold, or would the parent be unenrolled and need to reapply for the service?

• A: As you set up this self-directed attendant care service with your waiver nurse case manager, you will create an emergency plan. The emergency plan will help you prepare for emergencies such as illness, hospitalization, etc. Communicate individual circumstances with your waiver nurse case manager to reduce breaks in services to your child.

Q: Should we go ahead and get certified in CPR and First Aid?

• A: At this time, we are preparing the waiver application for submission to our federal partners. We will know on or after October 1, 2024, if the application has been approved. More information regarding the training programs will be made available.

Q: Do we need to pay for the CPR/First Aid certification courses, or is there a free training or voucher available? The passing of this will help to improve so many lives on this waiver. It is truly appreciated the efforts in getting this passed and getting the much needed assistance we need.

• A: At this time, we are preparing the waiver application for submission to our federal partners. We will know on or after October 1, 2024, if the application has been approved. More information regarding the training programs will be made available.

Q: Where do we need to do the CPR and the demonstration?

• A: At this time, we are preparing the waiver application for submission to our federal partners. We will know on or after October 1, 2024, if the application has been approved. More information regarding the training programs will be made available. The demonstration of skills occurs in the home.

Q: If I am already a CNA do I have to take courses?
• A: A SCDHHS contracted vendor will review all training certifications and notify potential attendant caregivers if additional training is required.
Q: Do parents need to be hired via an in-home company like aides?
• A: No, attendant caregivers are not employees of in-home care agencies.
Q: So, if I understand correctly, we would have to go through training to do the daily care we already do for our own child?
• A: A nurse contracted with the University of South Carolina will work with your MCCW nurse case manager to ensure attendant caregivers are fully trained. The child's licensed health care provider completes the Physician Information form outlining the specific tasks the attendant caregiver will complete.
Q: Can both parents be an attendant?
• A: Yes, the family may identify more than one attendant to complete the service hours identified on the assessment. If approved, parents of minor children, relatives, legal guardians, family friend, etc. who meet the provider qualifications may serve as the attendant care giver.
Q: Is there an expiration date on your certification?
• A: A SCDHHS contracted vendor will review all training certifications and notify potential attendant caregivers if additional training is required.
Q: Will we need to submit to drug test and supervisor visits like aides?
• A: Attendants must be at least 18 years old and meet all provider qualifications. This includes passing a background check and demonstration of skills required to meet the health, welfare and safety needs of the child. The waiver nurse case manager will conduct monthly oversight of this service during regular care coordination contacts.
Q: Do they do the training in Spanish as well?
• A: Communicate individual circumstances with your nurse case manager. Translation services are available.
Q: So aside from the required training and completion of assessment. How long will it take to get onboard with the company that would pay you?
• A: The onboarding process varies and is based on a number of factors including submission of paperwork, completion of training, match visits, etc. Contact your waiver nurse case manager with questions or concerns.

SERVICE-SPECIFIC QUESTIONS
Q: What are the 7 care requirements?
• A: Attendant caregivers will perform a minimum of two activities of daily living (ADLs) which are bathing, dressing, eating, toileting, hygiene, mobility and transferring.
Q: What are the main differences between a PCA and an attendant?
• A: Personal care assistants provide support with ADLs and are not permitted to provide skilled tasks. Attendants provide support with ADLs requiring skilled tasks identified by the child's medical provider.
Q: Will parents be able to provide medication administration and/or tube feedings while clocked in for attendant hours?
• A: Attendant caregivers will only be paid to provide the specific delegated skilled tasks identified by the child's medical provider on the Physician Information form.
Q: How would it work with the child going to therapies?
• A: The service as designed is intended to be rendered in the home to support ADLs. However, SCDHHS is taking these comments under advisement.
Q: How is this set up differently than a parent taking care of an adult child (over 21)?
• A: The MCC waiver program serves children birth to age 21. Attendant care in other programs serves members over age 21. In those programs, relatives and legal guardians are allowed to serve as self-directed attendant caregivers. If the MCC waiver amendment is approved, parents of minor children, relatives, legal guardians, family friends, etc. who meet the provider qualifications may serve as the attendant caregiver.
Q: Why was it decided to limit this to only ADL care?
• A: CMS requires states to adhere to service definitions. CMS defines personal care as, "A range of human assistance provided to persons with disabilities and chronic conditions of all ages to enable them to accomplish tasks that they would normally do for themselves if they did not have a disability. Assistance may take the form of hands-on assistance or as cueing so that the person performs the task. Personal care services support activities of daily living (ADLs), such as bathing, dressing, toileting, transferring, and personal hygiene.
Q: I don't see it mentioned but curious if it would be an all or nothing program or can their be a hybrid— (for example my son currently receives 36 hours of PCA hours, would the parent be able to receive 24 hours work and still use an external PCA for

the other 12)
• A: The program is designed to expand the number of qualified individuals available to receive payment to provide care for children enrolled in the MCC waiver. All care hours are based on the assessed need of the child.

PARTICIPANT ELIGIBILITY
Q: Why only under age 20?
• A: The MCC waiver service program serves participants up to age 21.
Q: Is this only for Medicaid recipients?
• A: Yes, the self-directed attendant care services is for Medicaid recipients enrolled in the Medically Complex Children program.
Q: If the child is 1 year old, can I still do it?
• A: A child over the age of one assessed to need the service may receive the service.
Q: If already under the CLTC waiver, will the rep sign off?
• A: All waiver participants over the age of 18 must identify an authorized representative. The authorized representative may participate in the selection of the self-directed attendant caregiver.
Q: Does a diagnosis auto qualify for this program (i.e. Down syndrome)?
• A: To qualify for this waiver program, applicants must have a physical or chronic medical condition expected to last at least 12 months and meet hospital level of care.
Q: How do I get this waiver? I'm not sure but I think I'm on a few waiting lists for waivers.
• A: To qualify for this waiver program, applicants must have a physical or chronic medical condition expected to last at least 12 months and meet hospital level of care. To make a referral, please visit the following website: https://phoenix.scdhhs.gov/cltc_referrals/new.
Q: If we are already on the waiver will your child still need to be assessed again? We are also getting PCA hours.
• A: Participants are reassessed annually or as needs change. Contact your waiver case manager with specific questions.
Q: Will it be different if he becomes an adult before this goes into effect? He's 17 now.
• A: This service will be available to all participants enrolled in the MCC waiver service program. The waiver service program serves participants up to age 21.
Q: Is it 18 or is it until the child is 21, since the waiver is until the child is 21?
• A: For MCC self-directed attendant care, qualified parents of minor children up to 18 are able to serve as paid attendant caregivers. For waiver participants age 18 to 21, parents, relatives, legal guardians, family friends, etc. who meet the provider qualifications may serve as the attendant caregiver.

SERVICE LOCATION
Q. Attendant care was stated to be conducted in the home. What happens when therapy, school based or private, and public instruction also occur in the home? Will these attendants get paid where those that travel to therapies do not? Please see comment on who performs ADLs during therapies. As a side note, allowing public schools to bill Medicaid for therapy services is strictly voluntary and mandating that clients disallow public schools to bill could be an option to reduce overlap of services.
• A: Services are highly individualized. Discuss with your waiver nurse case manager when the attendant caregiver can be clocked in when other service providers are in the home.
Q. What if the family goes on vacation? Are they not allowed to provide attendant services in the vacation accommodations?
• A: SCDHHS is taking these questions under advisement.
Q. While I understand the goal is to minimize overlap of service, there are many that transfer 2-4 hours each way for appointments in which assistance with ADLs would be required during that time. Additionally, therapists and doctors would rarely provide assistance with ADLs while at their respective offices or clinics, and if they happen to do so on rare occasions, the parent/caregiver is likely to hear about how it isn't their responsibility. If the intention is to have the doctor or therapist assist with ADLs while in their care, SCDHHS must train them accordingly...
• A: SCDHHS is taking these questions under advisement.
Q. It was mentioned that the attendant service could not be performed in the hospital. While we try to envision all scenarios, I would like to provide one for you to consider. What if a client had private primary insurance and secondary Medicaid and they had met their primary out of pocket, in which the primary is paying 100% and Medicaid is paying 0%. Would the attendant be allowed to provide care in that situation since there is no overlap of service?
• A: CMS excludes certain settings as permissible settings for the provision of waiver services. These excluded settings include nursing facilities, institutions for mental disease, intermediate care facilities for individuals with intellectual disabilities, and

hospitals. Other Medicaid funding sources support services provided in these institutional settings.
Q: If it's to be performed in the home, what if we have to take the child out of the home for a doctor's appointment but the child is still in our care?
• A: Attendant caregivers will be paid to provide support of ADLs (bathing, dressing, eating, toileting, hygiene, mobility and transferring). The attendant caregiver cannot provide services while simultaneously transporting the participant. However, SCDHHS is taking these comments under advisement.
Q: Can this only be done in the home? I work at my child's school in order to provide her medical care (in addition to teaching) while there since there is no nurse available.
• A: This service is designed to be rendered in the participant's home. However, SCDHHS is taking these comments under advisement.
Q: For school aged kids, if you have to your job to care for the kid at school can you clock in or wait until you are home?
• A: Attendant caregivers have flexibility to structure this service according to the child's assessed needs.
Q: If your child is school age but does not go to school and does home instruction, how does that work?
• A: Attendant caregivers have flexibility to structure this service according to the child's assessed needs.
Q: When we had nursing, they went along to appointments and remained on the clock. Why not make it the same?
• A: The attendant care service is intended to be rendered in the participant's home. However, SCDHHS is taking these comments under advisement.
Q: This seems illogical at best and potentially harmful at worst. Under no circumstances should a parent have to choose between being paid for caregiving duties and providing adequate medical/therapy care for their children. I do not believe there is any rational reason to deny parents the opportunity to be paid for caregiving that occurs outside of the home. The care needs of medically complex children continue to exist outside of the home, therefore any caregiver who provides a child's extraordinary care needs should be able to be paid for providing that care regardless of location. I sincerely hope that DHHS will remove the stipulation that parents can only be paid for care provided in the home.
• A: SCDHHS is taking these comments under advisement.
Q: I am a pediatrician in Columbia and mom to a disabled child enrolled in the medically complex children's waiver. I am concerned that the waiver amendment appears to stipulate that paid parent caregivers may only log paid hours within the home. I feel this is a critical mistake that could impact the health and well-being of children receiving attendant care in South Carolina. First and foremost, medical care and therapeutic interventions MUST be prioritized for all children. To disincentivize parents of medically complex children from prioritizing medical and therapeutic care for their children is wildly irresponsible. Children will suffer if parents are forced to choose between being paid and providing adequate medical/therapeutic care for their children. Furthermore, community activities are critical for both disabled children and non-disabled community members. Children with disabilities, even those with medical complexities, belong in the community. Denying parent caregivers the opportunity to be paid for activities outside of the home reinforces societal expectations that people with disabilities cannot and should not be active in the community. This is ableist and will harm children, families, and our state as a whole. Disabled children with extraordinary care needs continue to have those extraordinary care needs outside of the home (in fact I would argue that a child's needs are often magnified outside of the home environment). Therefore, parents acting as paid caregivers for children with extraordinary care needs can and should be paid for providing that extraordinary care outside of the home just as they can be paid for providing extraordinary care within the home. If extraordinary care needs exist, caregivers should be paid for providing that care regardless of location.
As a pediatrician and mom to a medically complex child, I sincerely hope that DHHS will consider modifying their proposal to remove the stipulation that parent caregivers may only be paid for activities in the home. Not only is it unfair to families but it could be truly harmful to vulnerable children.
• A: SCDHHS is taking these comments under advisement.
Q: I would like to start by saying that I am truly grateful for this to be an option! I do, however, want to voice some concerns. On the Webinar slides, Attendant Care was defined as "extensive hands-on assistance for at least two of the seven key activities of daily living (ADLs) (i.e., bathing, dressing, eating, toileting, hygiene, mobility, and transferring)." I understand this is intended to be used only for in-home care, however, if the criteria is that the child needs "extensive hands-on assistance for at least two of the seven key activities of daily living", that will not change when they are out in public. If my medically complex daughter needs extensive assistance while at home because she is unable to toilet independently requiring the use of diapers, eats solely via a feeding tube, and is not mobile requiring maximum assistance in moving/transferring, this will not miraculously change because we are out in public. She will still require all of that extensive assistance while we travel to appointments and in-clinic therapies. There have been many times that I have to change blowouts in the car on the way to or from appointments--which typically requires a complete wipe down with personal hygiene wipes, an entire outfit change, and needing to transfer to and

from her seat in the car. I think it should also be noted that so much money goes towards getting these children services so that they are not separated from society, but rather included. If families are forced to keep their children home because they need that financial assistance and it inhibits the child being able to interact with others, then it feels like a huge step backwards from inclusion of those with severe medical complexities.
• A: SCDHHS is taking these comments under advisement.
Q: The biggest concern I have with the proposed change is the requirement that all care hours must happen in the home. We have advocated so hard for so long to have our children live inclusive lives in the world around them. This requirement forces our kiddos into segregation. This would deteriorate their quality of life, not enhance it.
• A: SCDHHS is taking these comments under advisement.
Q: Based on what was presented today, am I correct in understanding that once clocked in, we are unable to leave the home prior to clocking out? This severely ties the hands of parents.
• A: The service is designed to be delivered in the participant's residence. However, SCDHHS is taking these comments under advisement. Self-directed attendant caregivers will use an app to clock in and clock out to initiate billing for the specific services rendered to the child.
Q: The main issue that I see with the proposal is the requirement that states all of the care hours must happen within the home. So many parents and families have worked and advocated for so long to have our children included in the world around them. They need to be out in the community and be able to experience life as we do. This requirement forces our children to be shut in and not be able to experience life as they should. This would limit their opportunities and choices. We as parents should be able to have this choice!!!
• A: SCDHHS is taking these comments under advisement.

ASSESSMENT
Q: Will the current nursing service be the one who determines the necessary skills to be performed?
• A: The child's medical provider will determine the delegated skilled tasks the attendant caregivers will perform.
Q: Will the licensed professional doing our child's evaluation be their MCCW nurse or someone else?
• A: The personal care assessment is conducted by the waiver nurse case manager. A Physician Information form is completed by the child's medical provider. A University of South Carolina contracted nurse will observe the attendant caregiver demonstrate the skills identified on the Physician Information form. The waiver nurse case manager will provide ongoing oversight of the service provided by the attendant caregiver.
Q: Is the assessment for attendant care vs nursing care available for review?
• A: Yes, both tools are available for review. Please contact your waiver nurse case manager for more information.
Q: What type of assessment will determine the hours awarded.
•A: SCDHHS will continue to use the current in-home hours guide to assess children for personal care hours.
Q: The other question I have is regarding the Assessments and verification of skills etc. Why would the Nurse case manager through the waiver not continue to do this for this piece as well. They are already familiar with our kids, already assessing their needs for aid hours etc., and they are already representing the state through their work for the MCC Waiver.
•A: The waiver nurse case manager will oversee and monitor the provision of the attendant care service. A contracted nurse will conduct the match visit in accordance with pre-existing policy.

EMPLOYMENT RELATED QUESTIONS
Q: Can you do this if you also have a full-time job?
•A: Self-directed attendant care must be provided in the child's home. You may work, as long as the outside work does not interfere or negatively affect services provided by you to your child. The identified care needs of the child must be the top priority. Discuss special circumstances with your waiver nurse case manager. Attendant caregivers have flexibility to structure this service according to the child's assessed needs.
Q: Hello, may I have information on the Parent/Caregiver position?
•A: SCDHHS is in the process of seeking approval from our federal partners to include attendant care service in the waiver. If approved, you will contact your waiver nurse case manager to begin the process to become a paid attendant caregiver.

ALLOCATION OF HOURS
Q: Can both parents split the approved hours?
•A: There may be several attendant caregivers identified to meet the assessed needs of a participant, but services from each attendant may not be provided at the same time. If the child is approved for more than 40 hours of care per week, there will need

to be a second attendant caregiver to finish the total hours approved. The second attendant caregiver can be another family member or a regular PCA through an agency.
Q: Does a full job a parent already has affect eligibility for the 40 hours? Does the 40 hours maximum worked allowed only relate to the approved waiver hours, not include the parents other job?
•A: Not every child will receive 40 hours. The hours are determined by the child's assessment. A self-directed attendant care provider cannot be paid to provide over 40 hours of attendant care per week.
Q: Is there a cutoff time to clock out? Can you be clocked in at night?
•A: Attendant caregivers have flexibility to structure this service according to the child's assessed needs. Attendant caregivers must be attentive and are not permitted to sleep while being paid to render services.
Q: Can both parents be attendants, and each get 40 hours in same household if qualified for that number of hours?
•A: There may be several attendant caregivers identified to meet the assessed needs of a participant, but services from each attendant may not be provided at the same time. If the child is approved for more than 40 hours of care per week, there will need to be a second attendant caregiver to finish the total hours approved. The second attendant caregiver can be another family member or a regular PCA through an agency.
Q: Can hours be done on the weekends?
•A: Attendant caregivers have flexibility to structure this service according to the child's assessed needs.
Q. Page 49 states: Participants are eligible to receive the number of attendant care hours as determined by a validated assessment. Legally Responsible Individuals (to include a parent) serving as the attendant have the option of rendering all or a portion of the hours (up to 40 hours). When the assessed need of the participant is greater than 40 hours per week, every effort should be made to identify an additional provider. It is not clear why additional providers should be identified over 40 hours per week. Can you please elaborate as to why every effort should be made to do so? For example, if a client was assessed at 42 hours per week and had medical conditions such as autism spectrum disorder that thrives on routine and schedule, then requiring an additional person for 2 hours per week might hinder improvements or assistance with ADL goals, not to mention be impossible to find a provider willing to work only 2 hours per week.
•A: SCDHHS requires a second qualified caregiver to meet the needs of children assessed to need more than 40 hours of care within a given week. This is intended to reduce the risk of caregiver stress and burnout and ensure high quality delivery of the extraordinary direct care required by the child. In the example above, the child may benefit from care received by providers sharing responsibilities of providing hours equally (i.e. 21 hours per attendant).
Q. Page 49 further states: If an attendant is approved to provide care for more than one participant, every effort must be made to ensure the attendant does not exceed 40 hours per week for the combined hours for all participants. It is not clear why additional providers should be identified over 40 hours per week. Can you please elaborate as to why every effort should be made to do so?

•A: SCDHHS requires a second qualified caregiver to meet the needs of children assessed to need more than 40 hours of care within a given week. This is intended to reduce the risk of caregiver stress and burnout and ensure high quality delivery of the extraordinary direct care required by the child.

ATTENDANT HOURS VS. NURSE HOURS VS. PERSONAL CARE AIDE HOURS
Q: That's what I'm trying to understand, I have two disable kids one with chronic lung disease, and my other child you have to watch at all times, how do this help me? So, this mean my aide will still be able to get her time, and me or another family member can do the other 40hrs?
•A: Not every child will receive 40 hours. The hours are determined by the child's assessment. A self-directed attendant care provider cannot be paid to provide over 40 hours of attendant care in a given week. The attendant care service is intended to help ensure all service needs are met. The attendant will become a paid member of the in-home care team working to meet the needs of the child.
Q: How will this impact my aide hours?
•A: The attendant care service is optional. It is intended to help ensure all service needs are met. If elected, the attendant caregiver will become a paid member of the in-home care team working to meet the needs of the child.
Q: Can we use nursing hours and PCA hours?
•A: All services are determined by assessment. If the child is assessed to need nursing and assessed to need PCA hours, both services can be utilized.
Q: Again to clarify, this impacts aide hours. We will basically have the choice to claim the aide hours for ourselves or hire someone like we've been doing, correct?
•A: The attendant care service is optional. It is intended to help ensure all service needs are met. If elected, the attendant will

become a paid member of the in-home care team working to meet the needs of the child.
Q: If our child already is qualified for hours with a nurse through the waiver already, will those hours be the same as this?
•A: No, all services are determined by assessment. If the child is assessed to need nursing and assessed to need PCA hours, both services can be utilized. The nursing and PCA hours are separate.
Q: Just to confirm, if we are already on the MCC waiver with hours for a PCA, we will have to reapply and figure out how many hours we qualify for again?
•A: Current waiver participants will have the option to identify an attendant caregiver to provide the personal care services currently authorized. New waiver applicants will require an assessment to determine the number of authorized hours for the service.
Q: Please forgive me for repeating any already answered questions: So, a child on MCCW could technically qualify for nurse, PCA and attendant hours correct? And we'd be "clocking in" at the current time (like aides do in Authenticare) as opposed to by the end of the week (like the aides for DDSN)?
•A: Yes, that is correct. MCC waiver participants could qualify for nurse, PCA and attendant hours. The attendant would clock in and out each time services are rendered using the Authenticare app to indicate service delivery completion.
Q: My daughter is currently approved for 55 hours of nursing care a week… would that still allow me 40 hours as an attendant during the hours nursing care is not provided?
• A: The attendant care service assessment is different from the nursing assessment. The attendant will be allowed to provide all or a portion of the attendant care service hours up to 40 hours per week. If the child is approved for more than 40 hours of care per week, there will need to be a second attendant caregiver to finish the total hours approved. The second attendant caregiver can be another family member or a regular PCA through an agency.
Q: So the nurse needs to clock in and out?
•A: All in-home care providers are required to clock in and out. In-home providers include nurses, personal care aides, and attendant care providers.

TREATMENT OF INCOME/RATE OF PAY
Q. Several times, the question of whether one could work full time and be an attendant was asked. While we try to envision all scenarios, I would like to provide one for you to consider. What if an attendant was receiving spousal social security benefits to care for an adult child (18-21 on this waiver)? Could they also get paid for attendant care? The social security benefit is not an hourly rate or direct service.
• A: Always consult with a tax professional about your individual family's circumstances and whether this income will be taxable. Families receiving benefits from other programs such as SSI or WIC should consult the appropriate program contact person.
Q: Other states do it and it doesn't affect SSI and they get additional hours, can you team up with them since theirs works?
•A: Always consult with a tax professional about your individual family's circumstances and whether this income will be taxable. Families receiving benefits from other programs such as SSI or WIC should consult the appropriate program contact person.
Q: Can we do anything before October of 2024 to start getting paid when it starts?
• A: At this time, we are preparing the waiver application for submission to CMS, our federal partners. We will know on or after October 1, 2024 if the application has been approved.
Q: If this approves and you apply after October 1 how long would the process take to begin getting paid?
• A: At this time, we are preparing the waiver application for submission to our federal partners. We will know on or after October 1, 2024 if the application has been approved.
Q: Will State and Federal taxes be collected?
• A: Always consult with a tax professional about your individual family's circumstances and whether this income will be taxable. Families receiving benefits from other programs such as SSI or WIC should consult the appropriate program contact person.
Q: Since there's up to 40 hours, is there a base hourly pay or monthly salary?
• A: On average, after training is complete and services are provided, attendant caregivers will receive payment twice a month. Self-directed attendant caregivers will receive a rate of $16.20 per hour. Attendant caregivers will only be paid to provide the specific delegated skilled tasks identified by the child's medical provider on the Physician Information form.
Q: What is the pay?
• A: Self-directed attendant caregivers will receive a rate of $16.20 per hour. Attendant caregivers will only be paid to provide the specific delegated skilled tasks identified by the child's medical provider on the Physician Information form.

Q: How would both having a nursing aid and a parent both being paid by the state hold up to public scrutiny?
• A: All services are determined by assessment. If the child is assessed to need nursing and assessed to need PCA hours, both services can be utilized. The nursing and PCA hours are separate.
Q: How do I get the full amount of hourly pay, of $16.20 hourly? I certainly am doing all the work for my son, past the 40 hours allotted, but am only making $15 an hour.
• A: Self-directed attendant caregivers will receive a rate of $16.20 per hour, up to 40 hours per week. Self-directed attendant caregivers do not work for an agency and will receive the full rate of pay.
Q: My understanding is if you become self-directed then you have to keep up with payroll and taxes, but I may be wrong???
• A: Always consult with a tax professional about your individual family's circumstances and whether this income will be taxable. Families receiving benefits from other programs such as SSI or WIC should consult the appropriate program contact person.
Q: Is the pay rate for parent who is a nurse still $16.20?
• A: The rate of pay for the attendant care service is $16.20 for all attendants.
Q: Will the pay be weekly or bi-weekly?
• A: On average, after training is complete and services are provided, attendant caregivers will receive payment twice a month.
Q: Would this count as a 1099 employee? So self-employed earnings?
• A: Always consult with a tax professional about your individual family's circumstances and whether this income will be taxable. Families receiving benefits from other programs such as SSI or WIC should consult the appropriate program contact person.
Q. While $16.20 is a great start with the numbers listed above and the amount of money it cost to raise a child with special needs this could use some improvement comparatively with other states providing this same ability to parents. While in the proposal it is being suggested to pay PCA $25 an hour and I understand that is to an agency there is room to improve the self-directed pay. While PCA's are not able to administer medications or provide advanced skills mentioned that parents may be trained to provide for their child. While a g tube and feedings would be part of ADL because the child could not do that themselves a PCA is unable to do that but a self-directed assistant can and will make less per hour. While most kids on this waiver qualify for PCA's it's almost impossible to get this service due to the quality of people working for these agencies. We have been asked to sign releases for felonies to come into our home, no shows, people with no cars asking us to come and get them to provide this service, cancelations, and a list of other issues. With a child with special needs all your child truly has to rely on is the parents.
• A: SCDHHS thanks you for your comment.
Q. Page 15. The response states: The current rate for attendant care (a self-directed service) is $16.20/hour. Will the attendant be paid overtime for hours over 40 hours in any given week? Will the attendant be paid overtime for state holidays under this waiver?
• A: Service hours will be determined by an individualized assessment. If the waiver participant is assessed to need more than 40 hours within a given week, there will need to be a second attendant caregiver to finish the total hours approved. The second attendant caregiver can be another self-directed attendant caregiver, or a personal care aide employed by an agency. Self-directed attendants will work with the family to customize the work schedule to accommodate the needs of the child. Attendants will not be paid a higher hourly rate for state holidays.
Q: Will we have to fill out a w-2 for taxes being withheld? This is not a how will taxes work question, it is a procedure question. I fully understand that I need to speak to a tax professional impact on taxes questions.
A: SCDHHS contracts with a fiscal management agency. This agency will help families address all payment and income related questions. SCDHHS also recommends families consult a tax professional to address your individual circumstances.
Q: Also for families that receive SSI payments for their child can they also be the attendant for their child.? Or if the parent is on SSI can they receive this income?
• A: Always consult with a tax professional about your individual family's circumstances and whether this income will be taxable. Families receiving benefits from other programs such as SSI or WIC should consult the appropriate program contact person.

ACCESSING PUBLIC COMMENTS /RECORDED WEBINAR
Q: Where are public comments captured?
• A: The public comments are incorporated in the waiver application. Frequently asked questions will be made available once all comments and questions have been compiled.
Q: How will I know about the next webinar?
• A: Webinar registration information was mailed to the address on file for all currently enrolled MCC waiver participants.

Registration information has been posted on the agency website at: https://www.scdhhs.gov/communications/public-notice-proposed-action-amending-medically-complex-children-waiver.
Q: Where do we access the recording of this webinar?
• A: The webinar recording is available on the SCDHHS website at: https://www.scdhhs.gov/resources/waivers/medically-complex-children-mcc-waiver.
Q: Will these slides be available afterwards?
• A: The webinar recording is available on the SCDHHS website at: https://www.scdhhs.gov/resources/waivers/medically-complex-children-mcc-waiver.

PROVIDER STAKEHOLDER COMMENTS
Q: A few questions as I work for a provider in the webinar, the speaker said this is open to anyone that the client or parent hires. I brought up foster parents. Are they eligible even though they are already being paid by the state to care for the client?
• A: By definition, self-directed attendant caregivers may be the parent of a minor child (including biological, adoptive, stepparent, or foster parent), a relative, a legal guardian or other individual selected by the family. Self-directed attendant caregivers must be at least 18 years of age and meet all SC Medicaid provider qualifications. Foster parents are advised to contact their DSS Caseworker to discuss eligibility to receive payment for the service.
Q: If these hours are split between an attendant and CPCA, how does a provider know if the attendant bills during the same time as the CPCA? And if our billing is kicked out, how do we get paid?
• A: The attendant care service is separate and distinct from the personal care service just as personal care and nursing are separate and distinct services. A separate service authorization will be generated for each service. Attendants, PCAs and other in-home care providers are required to clock in and clock out of the electronic visit verification (EVV) system in accordance with policy. Billing issues will be addressed in accordance with policy.
Q: Is this taxable income? Asking a tax professional is not an answer as they need to know if they will be taxed or not.
• A: SCDHHS contracts with a fiscal management agent to assist families with receipt of payment. Information about the fiscal agent, Morning Sun Financial Services can be found at https://morningsunfs.com/states/south-carolina/
Q: As a provider, we have to carry workers comp and liability. We are also liable for employees in the event that there is a negative outcome for the client. With this attendant care, who is responsible for these attendants?
• A: The nurse waiver case manager is required to provide monitoring and oversight of all services on the individualized plan of care plan. Attendant caregivers are required to meet all Medicaid provider qualifications and adhere to attendant care policies. Questions regarding worker's compensation and liability should be addressed to the fiscal management agency, Morning Sun Financial Services. The website is provided is provided below. https://morningsunfs.com/states/south-carolina/
Q: Who audits the services they provide?
• A: Post utilization audits will be conducted by SCDHHS.
Q: Is there going to be a forum for providers letting them know of these services as this is going to be very detrimental to a lot of CPCA providers.
• A: Information will be made available to all stakeholder groups during the planning, implementation and ongoing monitoring phases of this new service.
Q: Why is this service not limited to parents only?
• A: The purpose of this amendment is to provide additional provider options to ensure access to care. The self-directed service delivery option increases access to care for MCC participants. Limiting self-direction opportunities to parents only does not achieve the goal of increasing access to care.
Q: The policy states legal guardians cannot be paid caregivers to their adult children but with this they will be able to provide those services until they turn 18?
• A: The July 1, 2023, policy states legal guardians cannot provide agency-based services. If this amendment is approved by CMS, MCC participants who qualify for this service may identify qualified legal guardians to provide self-directed attendant care services. The MCC waiver program serves participants up to age 21.
Q: Are these services going to be audited like providers?
• A: The attendant care service is audited per the attendant care service scope.

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:

Health Programs

(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:

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:
As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the state. Thus, this section does not need to be completed.

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.:*

-Hospital LOC assessments for waiver applicants/participants are performed by a Care Services Organization(CSO).

-Pre-admission Screening (PAS) function is used to determine medical eligibility of the applicant/participant for the waiver program and is performed by a CSO.

○ **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:

The SCDHHS Phoenix Case Management system (Phoenix System) is used by SCDHHS staff to review the LOC assessments performed by the CSO to ensure the LOC criteria is met.

SC DHHS Phoenix Case Management system (Phoenix System) is used by SCDHHS MCCW staff to review the pre-admission screening (PAS) tool performed by the Care Services Organization (CSO) to ensure the PAS criteria is met.

The Phoenix database system is an automated electronic system used to perform a number of critical functions. SCDHHS uses the Phoenix System and has oversight of all intake, assessment, authorizations of services and care planning activities. The Phoenix database system also manages provider lists, quality indicators, and edits to ensure compliance with federal regulations and state policies.

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 will utilize: 1) Quarterly a representative sample of Level of Care (LOC) determinations are reviewed to ensure the LOC criteria is uniformly applied; 2) Annually, quality assurance focus reviews on the CMS quality assurance indicators and performance measures.

SC DHHS Phoenix Case Management system (Phoenix System) is used by SCDHHS MCCW staff to review the pre-admission screening (PAS) performed by the Care Services Organization (CSO) to ensure the PAS criteria is met. SC DHHS MCCW staff review each section of the Medical Eligibility Assessment tool utilized to perform the PAS. This occurs with every referral to MCCW.

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	Contracted Entity
Participant waiver enrollment	☒	☐
Waiver enrollment managed against approved limits	☒	☐
Waiver expenditures managed against approved levels	☒	☐
Level of care waiver eligibility evaluation	☒	☒
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	☒	☐

Function	Medicaid Agency	Contracted Entity
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 State's quality improvement strategy, provide information in the following fields to detail the State's 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:
Number and percent of annual case management activity quality assurance reviews completed required by policy completed. N:Number of case management activity quality assurance reviews completed D: Total number of case management quality assurance reviews required by SMA policy.

Data Source (Select one):
Provider performance 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 compliance issues that were remediated within specified timeframes. N = number of compliance issues remediated within specified timeframes. D = number of compliance issues requiring remediation.

Data Source (Select one):
Trends, remediation actions proposed / taken
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 State's 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.

The State (SCDHHS) retains full operational and administrative authority of this waiver. SCDHHS contracts with providers to perform waiver functions. Providers are responsible for implementing corrective actions as instructed by SCDHHS. SCDHHS uses the Phoenix Case Management System to track multiple participant and provider activities including enrollments, LOC Assessments, service plans, monthly and quarterly contacts and complaints.

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 Sub Group	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	0	21	☐
	☐	Technology Dependent			☐
☐ Intellectual Disability or Developmental Disability, or Both					
	☐	Autism			☐
	☐	Developmental Disability			☐
	☐	Intellectual Disability			☐
☐ Mental Illness					
	☐	Mental Illness			☐
	☐	Serious Emotional Disturbance			

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

Children with a serious illness or condition expected to last at least 12 months. The waiver participants must meet the state defined medical criteria which identify the child as being dependent upon the evaluation of dependency on medications, hospitalizations, skilled nursing services, ancillary services, and specialists.

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:

The State's Transition planning procedures will begin six months prior to age 21 to ensure transition to appropriate primary care and other home and community based waivers if eligible. Parents/responsible party will be provided information about other services, supports, and appropriate referrals available (i.e., state plan services and other waiver alternatives). The Nurse Care Coordinator is responsible for coordinating the transition to other services.

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	3091
Year 2	3091
Year 3	3091
Year 4	3091
Year 5	3091

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	2627
Year 2	2627
Year 3	2627
Year 4	2627
Year 5	2627

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).**

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:

Waiver applicants will be admitted to the waiver after they meet all criteria for enrollment. If there are not sufficient waiver slots, waiver participants will be admitted on a first come first serve basis, based upon date of the application.

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)*:

- (●) **Section 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**

☐ **SSI recipients**

☐ **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**

☒ **Optional state supplement recipients**

☒ **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)**

☒ **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:

SSI recipients,
Parents and other caretaker relatives: 42 CFR 435.110,
Transitional Medical Assistance – extended Medicaid due to earnings: Section 1925 of the Act,
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,
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, and
Independent foster care adolescents: Section 1902(a)(10)(A)(ii)(XVII) of the Act

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 section 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 section 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 (Section 1634 State/SSI Criteria 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 section 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 section 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:

Supplement 3 to Attachment 2.6-A of the State Plan outlines the following listing of Medical expenses which are allowable deductions from the recipient's monthly recurring income:

Eyeglasses not otherwise covered by the Medicaid program, not to exceed a total of $108.00 per occurrence for lenses, frames and dispensing fee. The necessity for eyeglasses must be certified by a licensed practitioner of optometry or ophthalmology.
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).
Denture repair which is justified as necessary by a licensed dental practitioner, not to exceed $77.00 per occurrence.
Physician and other medical practitioner visits above the 12 visit limit per fiscal year, not to exceed $69.00 per visit.
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 the staff of SCDHHS.
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.
Reasonable and necessary medical and remedial care expenses not covered by Medicaid incurred in the 3 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 an entity 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:

Licensed Nurses (RN and LPN) licensed by the State of South Carolina.

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.

The MCC Waiver hospital level of care criteria is utilized in the waiver. The MCC hospital level of care requires an evaluation of an applicant/participant's dependency on medications; hospitalizations; emergency room visits; skilled nursing level needs; physical, occupational, and speech therapy needs; and specialty care physician needs. Exceptions to the level of care criteria may be granted by the SCDHHS Medical Director if the applicant/participant is determined to be at risk for hospitalization, but does not meet the other level of care criteria. A standardized assessment tool ("Medical Eligibility Assessment Tool") is utilized to determine the complexity of the applicant/participant's medical condition.

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.

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:

The same processes and instrument are used to perform evaluations and re-evaluations. Initial LOC assessments are performed by licensed Nurses as part of the pre-admission screening function. Re-evaluations are performed by the nurse care coordinators.

MCC waiver administration staff assigns an authorization utilizing the Phoenix system for a Pre-Admission Screening (PAS) Children's Screening. A Pediatric, Nurse Care Coordinator completed a state Medical Eligibility Assessment tool. The following are evaluated for medical eligibility:

1. Number of medications given routinely
2. Number of hospitalizations, emergency room visits, and sick visits
3. Type of skilled care needs
4. Number of physicians involved
5. Number of therapies provided
6. At risk for hospitalization

If the waiver applicant is deemed Medically Eligible after completion of the Medical Eligibility Assessment (MEA) Tool, a Level of Care (LOC) assessment must be completed in the Phoenix Database System.

1. The Level of Care (LOC) assessment must be completed in the natural environment or hospital setting.
2. Upon completion of the Level of Care (LOC) assessment, the Level of Care determination is documented in the Phoenix Database System and the Nurse Care Coordinator sends a secure email to SCDHHS MCCW administrator requesting review, approval and signature.

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:

At least every 364 days from the previous level of care date.

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):*

The state currently operates an electronic case management system, Phoenix, that tracks the dates of all forms utilized in the maintenance of waiver operations. This includes LOC determination dates, and reports for upcoming and outstanding LOC. These reports are monitored by SCDHHS and Care Coordination staff.

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:

Electronic records are in the Phoenix Database System at SCDHHS.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's 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:
The number of new waiver applicants who met LOC prior to waiver enrollment. N = the number of new waiver applicants who met LOC prior to waiver enrollment; D = the total number of new applicants who enrolled.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Phoenix Data 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**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
The number and percent of all applicants who received a LOC determination. N: The number of applicants who received a LOC determination. D: The total number of applicants

Data Source (Select one):
Other

If 'Other' is selected, specify:
Phoenix Data 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**	☒ **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:

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:
The number of participants whose initial LOC determination was conducted using the correct instruments and process. N = number of participants whose initial LOC was conducted using the correct instrument and process; D = total number of initial LOC determinations.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Phoenix Data 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 = 95% +/-5
☐ **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:
The number of participants whose LOC re-evaluation determination was conducted using the correct instruments and process. N = number of participants whose re-evaluation LOC was conducted using the correct instrument and process; D = total number of re-evaluation LOC determinations.

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% +/-5
☐ **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.

SCDHHS will review the LOC assessment. The LOC assessment is part of the Phoenix Database System which ensures that only the approved instrument is used for all LOC assessments and re-evaluations. Phoenix will not allow entry into the waiver without a LOC assessment completed within the prior 30 days.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's 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.

During the enrollment process, SCDHHS will identify untimely LOC assessments. Based on the findings discovered, the provider is required to update the LOC prior to participant enrollment. If corrections need to be made, the SCDHHS will offer technical assistance/training. The QA Audit Tool is used to document these findings.

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).

The Nurse Care Coordinator discusses long term care options with the waiver applicant/Responsible Party (RP). Prior to waiver enrollment, a Freedom of Choice (FOC) form is secured from the RP to ensure he/she is involved in planning the waiver applicant's long term care, to document the choice of institutional or home and community-based services. This choice will remain in effect until such time as the RP changes his/her mind.

As part of the Freedom of Choice process, MCCW has a notification form “Medically Complex Children’s Waiver Freedom of Choice” that the participant and/or participant’s responsible party reviews and signs. This form includes the choice of location of services (including in the community with waiver services) and the choice of participation in the MCC waiver.

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 waiver participant Freedom of Choice (FOC) form is maintained indefinitely in the Phoenix Database System.

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):

SCDHHS is in compliance with Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons by using Global Interpreting Network for all interpretation and translation services. Global Interpreting Network will provide over-the-phone interpretation, face-to-face interpretation, document translation and face-to-face sign language interpretation. Nurse Care Coordinators have access to the appropriate Global Interpreting Network codes available to them for use on monthly phone calls and during quarterly home visits.

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	**Attendant Care**		
Statutory Service	**Nurse Care Coordination**		
Statutory Service	**Respite**		
Other Service	**Environmental Modifications**		
Other Service	**Pediatric Medical Day Care**		

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:

Personal Care

Alternate Service Title (if any):

Attendant Care

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08030 personal care
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Extensive hands-on assistance for at least two of the seven key activities of daily living (ADL) (i. e., bathing, dressing, eating, toileting, hygiene, mobility and transferring). This service is for waiver members unable to perform these tasks independently due to a medical condition identified and documented on a validated assessment. The need for assistance with ADLs relates directly to the member's physical and functional condition. The service must be medically necessary.

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

Participants are eligible to receive the number of attendant care hours as determined by a validated assessment. Legally Responsible Individuals (to include a parent) serving as the attendant have the option of rendering all or a portion of the hours (up to 40 hours). When the assessed need of the participant is greater than 40 hours per week, every effort should be made to identify an additional provider. If an attendant is approved to provide care for more than one participant, every effort must be made to ensure the attendant does not exceed 40 hours per week for the combined hours for all participants. Hours over the 40 hours may be covered by another individual selected by the participant, provided the individual has been determined to meet qualifications outlined in policy. Qualifications include successful demonstration of skilled care tasks, background clearance and the demonstrated ability to make decisions to protect the health and safety of the participant.

In emergencies, where another approved self-directed attendant is unavailable, an agency-based provider will be explored.

Self-directed attendants cannot render care to a participant more than 16 hours in a single day.

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
Individual	Attendant designated by waiver participant or authorized representative

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Attendant Care

Provider Category:

Individual

Provider Type:

Attendant designated by waiver participant or authorized representative

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Self-directed attendants must certify completion of the following trainings CPR, first aid, and medical training specific for medical condition(s). Attendants will be at least 18 years of age, capable of following a plan of service with minimal supervision, be free from communicable diseases and demonstrate competency in caring for the participant.

Verification of Provider Qualifications

Entity Responsible for Verification:

Nurse licensed by the State of South Carolina and employed by a contracted entity.

Frequency of Verification:

Upon enrollment and annually thereafter.

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):

Nurse Care Coordination

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):*

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

Nurse care coordination of attendant care provides an overview of the participant-directed service delivery model to interested parties. The overview includes roles, responsibilities, risks, and liabilities associated with participant direction.

Minimum limits of:
Face-to-face - quarterly
Telephone contact - monthly

Care Advocate Contact is contact by a professional who assists Nurse Care Coordinators by facilitating access to health services and interventions to maintain the participant through home support.

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

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 Services Organization (CSO)

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Nurse Care Coordination

Provider Category:

Agency

Provider Type:

Care Services Organization (CSO)

Provider Qualifications

License *(specify):*

Nurse Care Coordinator must be a licensed Registered Nurse or Licensed Practical Nurse (under the supervision of an RN) with a minimum of two years experience with medically complex children.

Certificate *(specify):*

Other Standard *(specify):*

Providers performing Nurse Care Coordination must be able to coordinate both long term care and acute care services for these children to ensure fully integrated care to prevent overlap of services and fully manage the needs of this population. All Care Service Organizations (CSO) must have the following:

1. The ability to interface with SCDHHS quality management, billing processes, and Phoenix software capability for treatment plan development.

2. Enrolled and contracted with SCDHHS as a qualified provider.

Verification of Provider Qualifications

Entity Responsible for Verification:

Medicaid Agency

Frequency of Verification:

Upon Enrollment and at least once every 18 months.

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:
17 Other Services	17990 other
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

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

The location(s) where respite care can be provided include, for example, the participant's home or private place of residence, the private residence of a respite care provider, a foster home, or a Medicaid certified Hospital. FFP is not claimed for the cost of room and board.

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

Respite may be provided up to 12 hours per month.

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	Nursing Agency
Agency	Personal Care Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Nursing Agency

Provider Qualifications

License *(specify):*

Code of laws 40-33-10 et seq

Certificate *(specify):*

Other Standard *(specify):*

Enrolled and contracted with the Medicaid Agency as a qualified provider.

Verification of Provider Qualifications

Entity Responsible for Verification:

Medicaid Agency

Frequency of Verification:

• Upon enrollment
• Within first year of service

• A sample of providers is reviewed every eighteen months thereafter

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Personal Care Agency

Provider Qualifications

License *(specify):*

Licensed by the South Carolina Department of Health and Environmental Control (SCDHEC) as a personal care agency. Pursuant to enactment and implementation of SC Code §44-70-10 all providers of personal care services will require a license to provide personal care services. Providers are required to renew their license annually.

Certificate *(specify):*

Other Standard *(specify):*

Enrolled and contracted with the Medicaid Agency as a qualified provider

Verification of Provider Qualifications

Entity Responsible for Verification:

SCDHEC; SCDHHS

Frequency of Verification:

• Upon enrollment
• Within first year of service
• A sample of providers is reviewed every eighteen months thereafter

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:

Environmental Modifications

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

14 Equipment, Technology, and Modifications

14020 home and/or vehicle accessibility adaptations

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope):*

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

These services may only be authorized based on a health and/or safety related issue. Nurse Care Coordinators must evaluate the expressed need prior to authorizing the service.
Air units are allowable when it is documented by a registered nurse or physician as being necessary due to an individual's physical condition and/or disability.

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

$7,500 life time monetary cap per waiver recipient.

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
Individual	Building Contractor
Agency	Licensed Business

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Modifications

Provider Category:

Individual

Provider Type:

Building Contractor

Provider Qualifications

License *(specify):*

SC Code 40-59-5

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

SMA, SC Department of Labor, Licensing and Regulation

Frequency of Verification:

Upon enrollment and at least once every eighteen months thereafter

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Modifications

Provider Category:

Agency

Provider Type:

Licensed Business

Provider Qualifications

License *(specify):*

Licensed business

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

SMA, SC Department of Labor, Licensing and Regulation

Frequency of Verification:

Upon enrollment

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:

Pediatric Medical Day Care

HCBS Taxonomy:

Category 1:	Sub-Category 1:
17 Other Services	17990 other
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

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

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

Services are limited to children ages 0-6.
Up to 45 hours per week.

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	Pediatric Medical Day Care

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Pediatric Medical Day Care

Provider Category:

Agency

Provider Type:

Pediatric Medical Day Care

Provider Qualifications

License *(specify):*

Code Sections 63-13-420 et Seq.

Certificate *(specify):*

Other Standard *(specify):*

Enrolled and contracted with SCDHHS as a qualified provider.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Social Services (DSS), and Medicaid Agency.

Frequency of Verification:

Upon enrollment and at least once every 18 months

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:

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):

SCDHHS provider contracts require credential and background checks be verified for the following provider types: Nurse care coordination, pediatric medical day care, and respite. These background checks are State level investigations conducted by the South Carolina State Law Enforcement Division for each provider's direct care staff. Individuals providing attendant care to waiver participants must also meet background check requirements.

Individuals are required to undergo criminal history and background checks prior to becoming an enrolled Medicaid provider.

Providers must check the Office of Inspector General (OIG) exclusions list for all staff. A copy of search results must be maintained in each employee's personnel file.

The state ensures that mandatory investigations have been conducted through periodic review of provider agencies and contracted vendors. In addition, an annual external quality review is conducted which includes verification of mandatory investigations.

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), as mandated by the South Carolina Code of Laws, maintains a registry which captures persons who have been convicted of abusing children under the age of 18. Abuse registry screenings must be conducted by agency providers on all direct care staff who provide Nurse Care Coordination, Pediatric medical day care and respite services prior to becoming an enrolled Medicaid provider. Individuals providing attendant care must also complete an abuse registry screen before becoming an enrolled Medicaid provider.

The state ensures that mandatory screenings have been conducted through periodic review of provider agencies.

Appendix C: Participant Services

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

Note: Required information from this page is contained in response to C-5.

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.*

Legally responsible individuals including parents of children up to age 21 may receive payment to provide attendant care to waiver participants. Payment may only be made for the services the individual has been certified as competent to complete by the contracted vendor. Reimbursable services must be rendered in the scope, frequency, and duration as identified in the person-centered plan. Only authorized services rendered by an approved attendant and confirmed by electronic visit verification are eligible for reimbursement.

Extraordinary care exceeds the range of activities that alegally responsible individual would ordinarily perform in the household on behalf of a person without a disabilityor chronic illness of the same age, and which are necessary to assure the health and welfare of the participant andavoid institutionalization.Reimbursable services are limited to those identified by the licensed professional on the identified SCDHHS form and must be rendered in the scope, frequency, and duration as identified and authorized in the person-centered plan. Only authorized services rendered by an approved attendant and confirmed by electronic visit verification (EVV) are eligible for reimbursement.

To ensure the provision of the service by a legally responsible individual is in the best interest of the participant, an evaluation by a licensed professional directly involved in the child's care must be conducted. If the licensed professional determines the child who has not reached the developmental milestones for his or her chronological age for the ADLs is considered to require assistance with ADLs, the licensed professional identifies the specific tasks the LRI will perform as the attendant. The specific tasks must be documented by the licensed provider on the SCDHHS designated form and included in the person-centered plan. The proposed attendant is required to complete a nurse match visit to demonstrate competency in performing identified tasks. The nurse match visit is facilitated by the contracted nurse vendor in the home of the participant. A match visit and review of required CPR and First-Aid training certifications and other specialized training identified by the licensed professional are required annually.

- ☒ **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:

Agency and Contracted Services - Nurse Care Coordination, Pediatric Medical Day Care, Respite, Environmental Modifications Agency staff may be related to participants served by the agency within limits allowed by the South Carolina Family Caregiver Policy. The following family members cannot be a paid caregiver: a. The spouse of a Medicaid participant (including married but separated); b. A parent of a minor Medicaid participant c. A stepparent of a minor Medicaid participant d. A foster parent of a minor Medicaid participant e. Any other legally responsible guardian of a Medicaid participant Self-Directed Services (Attendant Care) Family members who meet SMA provider qualifications may be reimbursed to provide attendant care. The family members for which payment may be made includes: a. A parent of a minor Medicaid participant; b. A stepparent of a minor Medicaid participant; c. A foster parent of a minor Medicaid participant; d. Person who has the legal responsibility of utilizing their own assets for the care of the Medicaid participant
When a LRI or relative/legal guardian is paid for provision of a waiver service, they are required to have a properly executed provider agreement.

Potential providers are given the opportunity to enroll as Attendant Care service providers with the SMA. Potential providers are made aware of the requirements for enrollment through: (1) Communication with the MCCW nurse case manager, (2) the agency's website and, (3) by directly contacting the SMA. Potential providers are directed to the SMA website to complete an online application. Once a potential provider has completed the enrollment application and subsequent process, the SMA enrolls them as an Attendant Care service provider.

Once a participant has chosen participant direction and is receiving services, case managers continue to monitor service delivery and the status of the participant's health and safety. Reports are monitored monthly to ensure service delivery and to ensure that the participant is receiving appropriate care. Case managers monitor these services during monthly contacts and quarterly face to face visits.

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:

Potential providers are given the opportunity to enroll/contract with the SCDHHS. Potential providers are made aware of the requirements for enrollment through:

1) The agency's website and
2) contacting the Medicaid agency directly.

Potential providers are given a packet of information that is used in the enrollment process. Some services specified in this waiver require pre-contractual review and signed contract for enrollment as a provider.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's 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 enrolled/contracted state providers who meet licensure, standards, and/or qualifications prior to the delivery of services. N = number of new enrolled/contracted state providers who meet licensure, standards and/or other qualifications prior to the delivery of services; D = total number of new providers who enroll/contract.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Contracted Provider Compliance Review

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):*

Performance Measure:
Number and percent of existing enrolled/contracted state providers who meet licensure, standards and/or other qualifications on an ongoing basis. N = number of existing enrolled/contracted state providers who meet licensure, standards and/or other qualifications; D = total number of existing providers who enroll/contract.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider Compliance Review

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 = +/-5%
☐ **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 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.

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 state providers whose staff meet the training requirements. N= number of state providers whose staff meet training requirements; D = total number of state provider staff.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider Training Records

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 = +/- 5%
☐ **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:

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 State's 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 contracts with providers to perform waiver services. Providers are responsible for implementing corrective actions as instructed by the SCDHHS. SCDHHS uses the Phoenix Case Management System to track multiple participant and provider activities including enrollments, LOC Assessments, service plans, monthly and quarterly contacts and complaints.

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 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.

Please refer to Attachment #2.

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

Service 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.

The person-centered service plan (PCSP) is developed through a person-centered planning process. The Participant and/or the Responsible Party (RP) will lead the person-centered planning process whenever possible. The PCSP is developed by a qualified Medicaid provider. Each participant and/or RP is offered the choice of qualified providers initially and annually thereafter, and may freely change qualified providers upon request throughout the year.

The Participant and/or RP is provided information about available waiver services along with the service provider choice form of available qualified providers. The Participant and/or RP is involved in the service planning and implementation process and may also include other person(s) of their choice in this process. The service plan agreement is signed by the Participant and/or RP.

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):

Person Centered Service Planning (PCSP) encompasses a comprehensive review of the waiver participant's needs and strengths. The service planning process allows for participation of the waiver participant, the Responsible party (RP), physician, service providers, and case management team. Service planning provides the involved persons with information necessary to make an informed choice regarding the location of care and services to be utilized.

Service planning includes coordination with other agencies who may be involved to ensure all services are considered in the development of the service plan. Completion and implementation of the service plan is a function of the nurse care coordinator.

Development of the Service Plan:

The person centered service plan is developed by the Nurse care coordinator from the assessment information, information obtained from the medical records and/or providers, input from the participant, RP, knowledgeable others, and agencies providing services to the participant.

All other payment sources, should be considered prior to using Medicaid services, including waiver services, in the service plan.

Each service plan should be individualized for a particular participant and completed so that a service professional unfamiliar with the participant can have a clear picture of what is being done for the participant.

Service Plan Components:

There are multiple components identified on the service plan. These components have applicable information which can be identified through the assessment instrument as follows:

1. Medical
2. Skin/Nutrition
3. Activities of Daily Living (ADL)
4. Instrumental Activities of Daily Living (IADL)
5. Psychosocial
6. Caregivers
7. Home Assessment Needs:

In order to develop a plan for intervention, a need must be identified in the assessment. When the service plan is created, all needs identified in the assessment must be included in the service plan. The needs listed on the Service Plan should be those needs with which the staff, and participant or parent/RP are actively working. Each listed need should have corresponding goals and interventions.

When the nurse care coordinator identifies services that are needed but unavailable, they should be included in the service plan as a need and identified as an unmet need under the intervention. The service plan must address all areas in which the participant requires at least limited/moderate assistance.

Planned Intervention:

Once a goal has been established, an intervention should be selected to reach the goal.

Service Plan Evaluation:

After the service plan is completed and implemented, it must be evaluated. A formal evaluation by a nurse care coordinator includes a review of the previously set goals to determine if they have been met. This review should determine if the stated need is still valid, if the activities to be implemented were carried out, and if the activities to be implemented are still appropriate.

A formal service plan evaluation by nurse care coordinator must be completed within at least 364 days from the previous

person centered service plan, or more often, as needed.

The Care Plan/Person-Centered Service Plan (CP/PCSP) is developed by the Nurse Care Coordinator and must address strengths and problems identified through the assessment process, with each listed problem having a corresponding intervention goal, current status and outcomes. The Medical Eligibility Assessment (MEA) and Level of Care (LOC) assessments inform development of the PCSP. The Nurse Care Coordinator creates the PCSP and it is routed to the MCC waiver administrator for review. At the time of initial assessment and at re-evaluations, participants are assessed for risks. The PCSP is monitored on a monthly basis by the Nurse Care Coordinator. The PCSP is designed to integrate medical management, home and community based services and State Plan services. Goals and interventions are developed as a joint effort between the participant, responsible party, physician and case management team. The Freedom of Choice form is completed to ensure that the participant or legal guardian is involved in planning long-term care. Planning meetings are scheduled at times and locations convenient to the individual.

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.

Participants' needs, including potential risks associated with their situations, are assessed and aimed at minimizing risks as addressed in the plan and during the annual plan process by helping an individual/legal guardian/caregiver view ways to be safe and within the choices made. The service plan includes a section for a description of the plan to be implemented during an emergency or natural disaster and a description for how care will be provided in the unexpected absence of a caregiver/supporter.

A standardized assessment tool is used for all waiver participants. This tool assesses the person's current situation, health and safety risk factors, and his/her personal preferences. The plan of service document includes sections that outline the responsibilities of the waiver participant, family, responsible party (RP), and the responsibilities of the nurse care coordinator. The qualified provider conducts training with staff annually to review proper reporting procedures for abuse, neglect, exploitation, and unexplained deaths.

Additionally, nurse care coordinators will encourage the RP to make back-up plans for emergencies when they take vacations or are away from home for extended periods of time.

If the Nurse Care Coordinator identifies any changes in the service needs of the waiver participant, they must be updated in the child's PCSP. PCSPs are monitored on a monthly basis. At the time of initial assessment and reevaluation, risks are identified and interventions/strategies to reduce risks are discussed. This may include additional monitoring to ensure health and welfare of the waiver participant.

The Nurse Care Coordinator is required to document the participant's emergency plan in the Phoenix database system in accordance with the Emergency Preparedness policy.

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.

Responsible parties (RPs) are given a list of providers with phone numbers, who serve in the area in which they reside. They are encouraged to phone providers with questions, ask friends or peers about their experiences with providers, research provider websites, and utilize other information resources, including support or advocacy groups in order to select a provider.

Participants/RPs may request a list of providers when service needs change, when a change is requested, or when selection of another provider is needed. The Nurse Care Coordinator may assist with questions about available providers but is not allowed to choose a provider for the waiver participant or RP.

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 service plans are in the Phoenix data base system. They are subject to review/approval by SCDHHS. The Nurse Care Coordinator submits the PSCP to the MCC waiver administration staff at the SMA. All plans are reviewed and approved by SMA waiver staff prior to implementation.

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:

At least every 364 days from the previous plan date.

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.

Nurse Care Coordinators monitor the person centered service plan on a monthly basis. This is performed by monthly phone calls and quarterly face to face visits. This monitoring also includes obtaining information about the waiver participant's health and welfare, as well as information about service delivery and appropriateness of interventions.

The Nurse Care Coordinator monitors the PCSP monthly and quarterly. A formal evaluation by the Nurse Care Coordinator includes a review of previously set goals to determine if they have been met. The review determines if the stated need is still valid, if the activities to be implemented were carried out, and if the activities to be implemented are still appropriate. Quarterly in-person assessments address safety of the waiver participant in the home, office of the primary care provider, or participant's natural environment. Long-term care options are discussed during the assessment and subsequent visits. The Freedom of Choice form remains in effect until such time as the waiver participant or legal guardian makes changes or the waiver participant is no longer eligible for the waiver.

The Provider Choice form lists providers and phone numbers for nursing, personal care and incontinence supplies. If the Nurse Care Coordinator identifies a need for additional services, such as Children's Personal Care Aide or Private Duty Nursing services, a Checklist for Medical Necessity and Nursing Acuity Scale are completed and scanned into the participant's file. The Nurse Care Coordinator is responsible for monitoring services and reviewing the claims section in the participant's file, comparing authorizations to actual services. The Nurse Care Coordinator must also assess satisfaction (complaints, grievances) with providers.
Brochures with contact information from the Transportation Broker are given to the participant/family.

The PSCP is re-evaluated on a monthly basis and is scanned into the participant's file in the Phoenix database system. Waiver administrator staff at the SMA have direct access to participant files in the Phoenix database system.

Monitoring the PCSP monthly during monthly contact ensures participants are receiving or offered all available services. This includes addressing the effectiveness of back-up plans.

The Nurse CC and Director of Care Coordination notify SC DHHS MCCW Administration with any follow-up and a performance improvement plan is placed for any remediation. If the problem only requires education that is documented as well. This ensures prompt follow up and remediation of identified problems.

To ensure systematic collection and compilation of information about monitoring results, the Nurse CC and Director of Care Coordination notify SC DHHS MCCW Administration through the Phoenix Case Management in the conversation section, place a narrative, as well as send a secure email to SC DHHS MCCW Administration.

b. Monitoring Safeguards. *Select one:*

- ◉ **Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements may not provide other direct waiver services to the participant.**
- ○ **Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements may provide other direct waiver services to the participant because they are the only the only willing and qualified entity in a geographic area who can monitor service plan implementation.**

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 State's quality improvement strategy, provide information in the following fields to detail the State's

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 participant plans that include services consistent with needs and goals identified in the assessment. N = Plans that include needs and goals identified on the assessment; D = the total # of Plans.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Phoenix 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 = +/- 5%
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and**	☐ **Other**

	Ongoing	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 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. N = # of plans that involved participants/responsible parties; D = total # of plans.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Phoenix 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 = +/-5%
☐ **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:

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's 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 that were updated within every 364 days. N = # of person-centered plans that were updated within every 364 days; D = total # of plans.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Phoenix 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**	☐ **Weekly**	☐ **100% Review**

Agency		
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = +/- 5%
☐ **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):*

Performance Measure:
The number and percent of participants with service plans updated/revised when participants' needs changed prior to annual review. N: the number of participants with service plans updated/revised when participants' needs changed prior to annual review. D: number of participants with changed needs prior to annual review.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Phoenix 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 = +/- 5%
☐ **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:

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 person centered plans that include provider type, service, amount, frequency and duration. N = # of plans that include provider type, service, amount, frequency and duration; D = total # of plans.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Phoenix 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 = +/- %5
☐ **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 participants/responsible parties who received face to face contact with the Nurse Care Coordinator within the required timeframe. N = # of quarterly face to face contacts conducted; D = total # of quarterly face to face contacts required.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Phoenix 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**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of participants who received non-face to face contact with the Nurse Care Coordinator within the required time frames. N = # of non-face to face monthly contacts conducted; D = total # of non-face to face contacts required

Data Source (Select one):
Other
If 'Other' is selected, specify:
Phoenix 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**	☐ **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:	

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**

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

Performance Measure:
Number and percent of participants who received services as designated in their service plans. N: Number of participants who received services as designated in their service plans. D: Total number of participants with service plans.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Phoenix 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 = 95% +/- 5
☐ **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:

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:
The number and percent of participants/responsible parties afforded choice of all qualified waiver service providers. N = # of provider choice forms offered; D = total # of case files.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Phoenix Data 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 = 95 % +/- 5
☐ **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:
The number and percent of participants/responsible parties afforded choice among waiver services. N = # of provider choice forms offered; D = total # of case files.

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% +/-5
☐ **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.

The State's Phoenix database system links the LOC assessment to the person centered plan of service. This ensures that all identified needs in the LOC assessment are addressed in the person centered service plan.

The Phoenix database system requires service authorizations to indicate the type, amount, duration, scope and frequency of services.

Additionally, the EVV automated monitoring system and mobile application with a GPS tracking system allows for real-time monitoring and verification of the providers delivering services.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's 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 SCDHHS identifies problems, the provider agency being reviewed is required to submit a plan of correction to address the issues discovered. If additional technical assistance is needed, SCDHHS will assist.

Depending on the findings, remedial actions may include provider training or recoupment of Federal Financial Participation (FFP).

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 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.

The Medically Complex Children waiver program provides attendant care, a participant-directed service with employer authority. This authority grants the participant or the designated authorized representative the option to choose their attendant and direct how the service is delivered.

The contracted Nurse Care Coordination vendor provides an overview of the participant-directed service delivery model to interested parties. The overview includes the roles, responsibilities, risks, and liabilities associated with participant direction.

The contracted Attendant Care vendor provides an extensive explanation of the roles, responsibilities, risks, and liabilities associated with the employer authority. Information about the hiring, management, and termination of workers as well as the role of the Financial Management System (FMS) entity is provided. The contracted Attendant Care vendor also trains individuals who will perform tasks associated with the employer authority.

The FMS entity provides support to the participant or designated authorized representative to ensure that federal, state, and local employment taxes and labor and workers' compensation insurance rules related to household employment and payroll are implemented in an accurate and timely manner.

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 waiver program allows participants or the participant representative to direct the attendant care service. Participant direction is not a service delivery option for any other service in the waiver.

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 assessment, the Nurse Care Coordinator will introduce and provide information about the participant-direction option to the participant or representative. The Nurse Care Coordinator will also provide this information at the request of the participant/representative. If the participant/representative is interested, the Nurse Care Coordinator will provide more details about the benefits and responsibilities of the participant-directed Attendant and determine continued interest. The Attendant Care vendor will provide extensive information about the benefits as well as the risks, responsibilities and liabilities of participant/representative direction.

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. To qualify for the role of the participant's representative, the interested party must be willing to understand and assume the risks, rights and responsibilities of directing the participant's care. A representative may be a legal guardian, family member, or a friend/known acquaintance of the participant. The chosen representative must demonstrate a strong personal commitment to the participant, knowledge of the participant's preferences and medical condition(s), and be at least 18 years of age. The representative must be willing/able to monitor and observe care. A representative will not receive payment for these services.

Once a participant identifies a representative for their services, the participant's case manager completes an initial screening assessment to ensure the representative is capable of functioning in the best interests of the participant. Additionally, the representative is required to acknowledge awareness of the participant's needs in providing their signature on the Rights and Responsibilities form.

Adult participants (aged 18 - 21) may elect a non-legal representative to direct the attendant care service.

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
Attendant Care	☒	☐

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 provide FMS as an administrative function to participants in the MCC Waiver. This service will be added to the State's current contract which was secured in response to a Request for Bid (RFB).The electronic visit verification (EVV) program is leveraged by the State to facilitate documentation of service delivery requiring payment to the Attendant by the FMS.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

A monthly fee per participant is charged for financial management 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:

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:

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.

In conjunction with interface through EVV, Phoenix documents the delivery of services by providers and compares submitted claims to authorizations to ensure appropriate service provision. The SMA receives files on a regular basis indicating payments that have been made to individuals providing self-directed services. These are compared with claims reports indicating money paid to the provider of FMS. The SMA has staff charged with ensuring provider payments are timely and accurate. Any discrepancies or other issues are discussed with FMS and resolved as appropriate. Under the existing agreement, the SMA may request a complete financial audit at any time. FMS makes payments bi-weekly and posts electronically to the SMA.

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:

Nurse Care Coordinators will provide detailed information to the participant or responsible party (RP) about participant/RP direction as an option including the benefits and responsibilities. If the participant/RP opts to pursue this service, additional information about the risks and responsibilities will be shared by the Attendant Care vendor. Information about the hiring, management and termination of workers as well as the role of the Financial Management System is also provided. Once the participant/RP has chosen to direct their services, Nurse Care Coordinators continue to monitor service delivery and the status of the participant's health and safety.

☒ **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
Environmental Modifications	☐
Respite	☐
Attendant Care	☐
Nurse Care Coordination	☒
Pediatric Medical Day Care	☐

☒ **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:

Medically Complex Children waiver participants or the designated authorized representative may direct the attendant care service. The following contracted entities provide information in support of participant direction:

Information and assistance associated with participant-direction - A contracted Nurse Care Coordination vendor provides an overview of the participant-directed service delivery model to interested parties. The overview includes the roles, responsibilities, risks, and liabilities associated with participant direction. This vendor is contracted with the SMA as a Care Service Organization and reimbursed for waiver care coordination/case management services in accordance with the terms of the executed contract. In addition to bi-weekly meetings with the SMA, the vendor undergoes a global review with specific emphasis on adherence to contract deliverables associated with the waiver care coordination/cased management function.

Information and assistance associated with employer authority - A contracted Attendant Care vendor provides an extensive explanation of the roles, responsibilities, risks, and liabilities associated with the employer authority. Information about the hiring, management, and termination of workers as well as the role of the Financial Management System entity is also provided. The vendor trains and certifies the individuals selected by the participant or responsible party who will perform tasks associated with the employer authority. The vendor is contracted with the SMA and is reimbursed for the provision of administrative activities associated with initial and ongoing monitorship to ensure attendants continually meet minimum requirements for self-directed Medicaid providers. The contract is executed on a five-year renewal cycle with oversight occurring during bi-monthly meetings with the SMA.

The contracted Financial Management System (FMS) vendor provides support to the participant or designated authorized representative to ensure that federal, state, and local employment taxes and labor and workers' compensation insurance rules related to household employment and payroll are implemented in an accurate and timely manner. The vendor receives payroll fund transfers from MMIS, processes payroll as well as the withholding, filing and payment of applicable employment-related taxes/insurances. The SMA provides financial management services in response to a Request for Bid (RFB). Services for which payment from the FMS vendor is required are validated by electronic visit verification. The vendor is contracted with the SMA as a Fiscal /Employer Agent and is reimbursed per the existing contract. Monthly meetings occur with the vendor and the SMA to verify accuracy of payments.

The SMA has determined the cost allocation plan will not be impacted by self-directed attendant care.

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:

Participants may elect to voluntarily discontinue participant direction at any time and may choose agency-driven options. Participant health and welfare is assured during the transition period of a voluntary termination of service direction. The termination of participant directed services and authorization of agency driven services are coordinated to assure continuity of services.

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.

Participants may be involuntarily terminated from the use of participant directed services when they are unable to direct their own care and have no representative willing and/or able to do so. Participants who are involuntarily terminated from participant directed services are given the option of receiving agency directed services. If a participant is involuntarily terminated from participant directed services, the termination of participant directed services and the authorization of agency directed services are coordinated to assure continuity of services. These safeguards exist to assure participant health and welfare during the transition period of an involuntary termination of service direction.

Participants who are involuntarily terminated are given written appeal rights.

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	0	
Year 2	0	
Year 3	1236	
Year 4	1236	
Year 5	1236	

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:

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:

Prospective workers must provide qualifying background checks to secure their position. The costs of background checks for leagally responsible guardians will be the responsibility of UAP (University Affiliated Programs/USC).

☐ **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:*

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

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

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

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.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

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.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

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

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

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:

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.

Any waiver participant/responsible party (RP) has the right to request an appeal of a decision that adversely affects his/her eligibility status and/or receipt of services. Waiver participants/RPs are informed of this decision in writing when an adverse decision is made. The formal process of review and adjudication of SCDHHS actions/determinations is done under the authority of Section 1-23-310 et. seq., Code of Laws, State of South Carolina, 1976, as amended, and the Department of Health and Human Services regulations Section 126-150, et.seq.

The State provides a written notice with instructions on how to appeal an adverse decision.

The waiver participant/RP must request an appeal within 30 days of the date of the official written notification issued by SCDHHS. Should the waiver participant/RP want to continue services pending the appeal, the RP must submit a request within the first 10 days of the appeal period.

Information regarding the waiver participant/RP's right to appeal and instructions for initiating an appeal are printed on the Adverse Notification form. Also included on this form is the information on requesting continuing services until the outcome of the hearing. In addition, waiver participant/RP may file an appeal electronically at www.scdhhs.gov/appeals.

Once an appeal has been arranged, the appeals examiner will notify the waiver participant/RP of the date, time, and location of the hearing via written notice.

Prior to entrance to the waiver and annually thereafter, participants are provided an Acknowledgment of Rights and Responsibilities form by the Nurse Care Coordinator that includes information about their rights, including the right to a fair hearing. Notice of appeal rights is provided to the individual at the time of any adverse action and is printed on the Adverse Notification form. Notices are kept in the participant’s case file in the Phoenix database system. Adverse actions include choice of provider or service.

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**

- **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.

Do not complete this item.

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**

• **Operational Responsibility.** Specify the state agency that is responsible for the operation of the grievance/complaint system:

The State Medicaid agency operates the Complaint/Grievance System.

• **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).

Complaints are taken at the SCDHHS central office. Waiver participants/responsible parties (RPs) are notified of their right to complain/grieve through a Participants Rights and Responsibilities statement reviewed and signed at the initial visit with the Nurse Care Coordinator. When a waiver participant/RP elects to file a grievance or make a complaint, the waiver participant/RP is informed that doing so is not a prerequisite or substitute for a Fair Hearing.

Types of complaints include: concerns about providers; reduction or termination of services; unmet needs; allegations of abuse; and/or any other complaint about services received under the waiver or state plan.

The Nurse Care Coordinator receiving the complaint fills out the complaint section in the Phoenix database system, initiates action to address the complaint and tries to reach resolution. The complaint is sent electronically to the quality assurance (QA) department, provider compliance department, and waiver staff. The complaints will generally be addressed within a month of receipt depending on the research required. Pending actions and complaint data are tracked and compiled by the Phoenix database system.

Actions taken to resolve complaints may include contact with the RP/participant, provider, referrals to supervisors and/or referral to child protective agencies or local law enforcement. In addition to the above, SCDHHS has a mechanism for receiving complaints through an Agency website. These complaints are directed to the correct division for attention and resolution.

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).

The South Carolina Child Protection Reform Act as specified in SC Code Ann. 63-7-10 et seq. requires reporting of abuse, neglect and exploitation (ANE) to those state agencies having statutory authority to receive reports and investigate allegations of suspected ANE. These agencies include Child Protective Services - South Carolina Department of Social Services (SCDSS), and local and state law enforcement agencies. These reports can be made by phone or written form. All verbal reports shall subsequently be submitted in writing. These incidents are defined as physical abuse, emotional, mental or psychological abuse, verbal, threatened or sexual abuse, neglect, and physical and financial exploitation. Mandatory reporters have a duty to report if they have information, facts or evidence that would lead a reasonable person to believe that a child has been or is at risk for ANE. Mandated reporters include medical personnel, physicians, nurses, professional staff, employees, and volunteers or contract provider agencies having a legal responsibility under state law to report suspected ANE to state investigative agencies. Mandated reporters must make the report within 24 hours or the next business day after discovery of the ANE.

The less critical events that do not warrant a referral to SCDSS for follow-up services are documented in the narrative and Inbox section of the Phoenix database system.

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.

Upon waiver enrollment, waiver participants/responsible parties (RPs) are provided written information about reporting ANE of children. The material provided explains what is considered ANE, and waiver participants/RPs are given phone numbers for reporting suspected abuse cases. Nurse Care Coordinators explain this information to participants/RPs during the initial visit.

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.

When there is reason to believe that a waiver participant has been abused, neglected, or exploited, in the home or other community setting, employees and other mandated reporters have a duty to report according to established procedures and state law. SC DSS is the mandated agency to investigate suspected ANE in these settings. SC DHHS and its contracted provider agencies shall be available to provide information and assistance to SC DSS. Procedures and time frames of 30 days have been established for SC DHHS to assist providers in resolving issues with SC DSS regarding intake referrals and investigations. SC DSS will conduct a complete investigation and contact law enforcement if criminal violations are suspected. If the investigation is substantiated, notification by SC DSS is sent to appropriate agencies for required actions to be taken. The reporting time frame is 24 hours from when the report is taken.

The South Carolina Child Protection Reform Act as specified in SC Code Ann. 63-7-10 et seq. requires reporting of abuse, neglect and exploitation (ANE) to those state agencies having statutory authority to receive reports and investigate allegations of suspected ANE. These agencies include Child Protective Services - South Carolina Department of Social Services (SCDSS), and local and state law enforcement agencies.

When reports are made pursuant to Section 63-7-310 of the SC Code of Laws to a law enforcement agency, the law enforcement agency shall notify the county department of social services (SCDSS) of the law enforcement’s response to the report at the earliest possible time.

Within twenty-four hours of the receipt of a report of suspected child abuse or neglect or within twenty-four hours after SCDSS ("the department") has assumed legal custody of a child pursuant to Section 63-7-660 or 63-7-670 or within twenty-four hours after being notified that a child has been taken into emergency protective custody, SCDSS must begin an appropriate and thorough investigation to determine whether a report of suspected child abuse or neglect is "indicated" or "unfounded".

The finding must be made no later than forty-five days from the receipt of the report. A single extension of no more than fifteen days may be granted by the director of the department, or the director's designee, for good cause shown, pursuant to guidelines adopted by the department.

SCDSS must furnish to parents or guardians on a standardized form the following information as soon as reasonably possible after commencing the investigation:

(1) the names of the investigators;

(2) the allegations being investigated;

(3) whether the person's name has been recorded by the department as a suspected perpetrator of abuse or neglect;

(4) the right to inspect department records concerning the investigation;

(5) statutory and family court remedies available to complete the investigation and to protect the child if the parent or guardian or subject of the report indicates a refusal to cooperate;

(6) how information provided by the parent or guardian may be used;

(7) the possible outcomes of the investigation; and

(8) the telephone number and name of a department employee available to answer questions.

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.

SCDSS Child Protective Services and local and state law enforcement are responsible for overseeing the reporting of and response to critical incidents on a monthly basis. In addition to investigations by the State Ombudsman, SCDSS, and law enforcement, other agencies have jurisdiction to make inquiries into incidents of abuse, neglect, or exploitation and may conduct their own investigation. These agencies include:

SLED/Child Fatalities Review Office: The Child Fatalities Review Office of the State Law Enforcement Division (SLED) will investigate all deaths involving abuse, physical and sexual trauma as well as suspicious and questionable deaths of children. The State Child Fatalities Review Office will also review the involvement that various agencies may have had with the child prior to death.

Disability Rights South Carolina (Protection and Advocacy): Disability Rights South Carolina has statutory authority to investigate abuse and neglect of people with disabilities.

The Nurse Care Coordinators will submit a report in the Phoenix database system of any critical events or incidents (e.g., medication errors, serious injuries that require medical intervention and/or result in hospitalization, or abuse/neglect).

SCDHHS is the state entity responsible for overseeing operating of the incident management system for MCC waiver participants. SCDHHS provides oversight by reviewing all critical incidents on a monthly basis to determine types of complaints and trends. Phoenix is used to monitor critical incidents. In order to prevent re-occurrences, SCDHHS tracks trends and makes reports to investigative agencies.

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:

SCDHHS does not permit the unauthorized use of restraints or seclusion for waiver participants. The nurse care coordinators monitor monthly with waiver participant/responsible party to ensure there is no unauthorized use of restraints or seclusion in the provision of services. SCDHHS reviews results of this monitoring using a sample review of case files.

○ **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:

SCDHHS is responsible for oversight of the nurse care coordinators, who monitor the person centered service plan, which includes asking the participant/responsible party about the unauthorized use of restrictive interventions.

○ **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:

SCDHHS does not permit the unauthorized use of seclusion for waiver participants. The nurse care coordinators monitor monthly with waiver participant/responsible party to ensure there is no unauthorized use of seclusion in the provision of services. SCDHHS reviews results of this monitoring using a sample review of case files.

○ **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)*

- **Medication Management and Follow-Up**

Do not complete this section

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.

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.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

Answers provided in G-3-a indicate you do not need to complete this section

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)*

• **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).

• **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:

(b) Specify the types of medication errors that providers are required to *record:*

(c) Specify the types of medication errors that providers must *report* to the state:

○ **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:

• **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.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's 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 percent of participants/authorized representatives who received information on how to report abuse, neglect, exploitation and other reportable incidents. N: The number of participants/authorized representatives who received information on how to report abuse, neglect, exploitation and other reportable incidents. D: The number of participants/authorized representatives.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Phoenix 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**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:

Number and percent of MCC Waiver participants with reports of ANE or UD whose internal review was completed within the required timeframe. N = Number and percent of MCC waiver participants with reports of ANE or UD whose internal review was completed within the required timeframe. D = Total number of MCC waiver participants with reports of ANE or UD.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Phoenix 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**
	☐ **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 reported critical incidents in Phoenix that are monitored until appropriate resolution. N = Number of reported critical incidents that are monitored until appropriate resolution. D = Total number of reported critical incidents.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Phoenix 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**	☐ **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:	

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**

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

Performance Measure:
Number and percent of MCC critical incident allegations reviewed within the required timeframe. N = number and percent of MCC critical incident allegations reviewed within the required timeframe. D = Total number of MCC critical incident allegations.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Phoenix 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**
	☐ **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 of unauthorized incidents of restrictive interventions that were appropriately reported. N = # of unauthorized incidents of restrictive interventions that were appropriately reported. D = Total # of unauthorized restrictive interventions for MCC waiver participants.

Data Source (Select one):
Other
If 'Other' is selected, specify:

Nurse Care Coordinator Checklist

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% (+/- 5%)
☒ **Other** Specify: Nurse Care Coordinators	☐ **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 MCC Waiver Participants who have been evaluated for Emergency/Natural Disaster preparedness. N: the number of participants who have an Emergency/Natural Disaster preparedness plan. D: total number of participant plans.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Phoenix 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 = +/- 5%
☐ **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 State's 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.

As abuse, neglect, and exploitation are identified, action is taken to protect the health and welfare of the waiver participant. The documentation regarding the ANE complaints is reviewed by SCDHHS. When appropriate action is taken by the appropriate parties (SCDSS, SLED, P&A, local law enforcement) and reported to SCDHHS, SCDHHS closes the ANE complaint in the Phoenix database system.

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 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 Phoenix database system can produce data associated with the outcomes tied to specified performance measures such as non-face to face nurse care coordinator monthly contacts, face to face quarterly nurse care coordinator contacts, timely initial and re-evaluations for Level of Care determinations, timely service plan development, provider or participant complaints, reports of ANE/critical incidents and narratives for nurse care coordinators. Reports can be generated regionally, statewide, by individual nurse care coordinators or agency. Data can be trended by specified performance measures. This process allows a thorough assessment of areas needing improvement and areas of best practice.

Prioritizing and implementing system improvements is based on the severity of identified problem(s) and the frequency of duplicated errors. Compliance that falls below 100%, (waiver assurance or otherwise) and issues that present as a statewide problem instead of a localized staffing concern, are addressed as priority. Systems Improvement may involve the following: 1) targeted staff training; 2) Revisions to the training program; 3) Revision of policy and procedure for clarification; and 4) Modifications to expand/improve the Phoenix data system.

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: On-going

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 for monitoring and analyzing system design and data: various information may be submitted on the Phoenix database system in order to generate reports from or about nurse care coordinators, other waiver service providers, waiver participant Level of Care status, waiver participant service plan development status, nurse care coordinator narratives and/or contacts, or ANE/critical incident or complaint reports. Caregivers/responsible parties may also call SCDHHS to submit complaints about their nurse care coordinator provider. This information is researched by the waiver administrator, logged into Phoenix and tracked for resolution.

Data is gathered and compiled from the following data sources: the Phoenix data base system; Provider Compliance Reviews conducted by SCDHHS staff at least every 18 months; participant/responsible party appeals and dispositions; quality assurance evidentiary reviews conducted by SCDHHS staff; and quarterly meetings/trainings with RN care coordination staff conducted by the Waiver Administrator.

ii. Describe the process to periodically evaluate, as appropriate, the quality improvement strategy.

Annually, the Medicaid Agency and CSO will review trended data to evaluate the overall quality improvement strategy. There is also the capability to report problems in the Phoenix data base system that allows issues discovered by users to be submitted to the Phoenix helpdesk for consideration or correction. This allows on-going quality improvement within the Phoenix data system.

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).*

The State employs the following methods to ensure the integrity of payments made for waiver services:

The state uses an Electronic Visit Verification (EVV) system that is a front line auditing tool ensuring the integrity of the payments for services. This system links authorized service amounts to claim billing to ensure that over-billing for services is prevented. The system is also used to generate various reports used to do more in depth auditing on issues related to where services were performed, the time and duration of the service, whether or not a waiver participant received an authorized service, etc. CMS has indicated that this tool is a best practice for states to utilize in waiver management.

The Division of Program Integrity at SCDHHS responds to complaints and allegations of inappropriate or excessive billings by Medicaid providers, and also collects and analyzes provider data in order to identify billing exceptions and deviations. In this capacity, Program Integrity may audit payments to waiver service providers. The Division of Program Integrity carries out SCDHHS responsibilities concerning suspected Medicaid fraud as required by 42 CFR Part 455, Subpart A.

Program Integrity must conduct a preliminary investigation and cooperate with the state and federal authorities in the referral, investigation, and prosecution of suspected fraud in the Medicaid program. SCDHHS refers suspected cases of Medicaid fraud by health care providers to the Medicaid Fraud Control Unit of the State Attorney General's Office for investigation and possible prosecution. 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.

The State does not require providers to secure an independent audit of their financial statements. SCDHHS staff review Phoenix reports such as Activities Task Sheets, Missed Visit Reports, Provider Activity Reports, Unauthorized Location and Unauthorized Phone Number Reports and compares them to provider's documentation of service delivery to ensure financial integrity. These Phoenix/EVV reports are reviewed to verify the following: 1) services being provided are identified on the participant's service plan; 2) activities being performed by the service provider; and 3) if the service is being provided in the participant's home. Nurse Care Coordinators generally review the participant records at least once a quarter to compare service authorizations against paid claims to ensure providers are not inappropriately reimbursed. Other SCDHHS staff, including Program Integrity, may also conduct reviews. These reviews are generally performed as desk reviews but could also be conducted as site reviews depending upon circumstances. A Program Integrity review may occur based on a complaint or Medicaid fraud, waste or abuse, or as the result of a referral from the Program Area. Generally, Program Integrity reviews identify the following information: NPI, background checks, MMIS provider enrollment information, review of provider contracts, detailed claims report, review of program policies, and conducts the review of participant and/or provider records against the period of review for the selected sample of participants. The same process applies regardless of provider type. The State requires a corrective action plan from providers if there are warranted findings. Providers receive a follow-up letter communicating the final results. The State Auditor's Office conducts audits of SCDHHS' programs.

If a corrective action plan is issued against a provider, depending on the sanction, the State will either conduct a site visit after 90 days to ensure that the corrective action plan was implemented or require the provider to submit documentation that was unavailable at the time of the site visit.

The Nurse Care Coordinators review each participant's case prior to his/her quarterly review date to ensure all authorizations are appropriate and reimbursed correctly.

Program Integrity reviews are generally independent of Program Area reviews. They accept referrals based on complaints or findings from the Program Area. Their sample sizes and methodology are not shared with the Program Area. They make both announced and unannounced visits to conduct reviews; their schedules are not shared with the Program Area and their findings are independent. The number of provider reviews conducted annually depend on a variety of factors. SCDHHS could be acting on a complaint or internally looking for specific findings such as billing irregularities, patterns of poor monitoring, undocumented waiver services, excessive waiver services or waiver services billed during inpatient admissions. Sample sizes may vary depending on suspected findings, staff capacity, resources and other ongoing projects such as Renewals, Amendments, Evidentiary Reports or CMS RAI or IRAI inquiries.

The South Carolina Office of the State Auditor coordinates the periodic independent audit under provisions of the Single Audit Act in conjunction with an external auditor.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's 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:
The number and percent of MCC claims that process through MMIS and pay according to approved reimbursement methodology. N = # and % of MCC claims that process through MMIS and pay correctly; D = total # of claims.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
MMIS claims report

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 =* *+/- 5%*
☐ **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 waiver 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 waiver claims verified during the waiver year. Denominator – total waiver claims during the waiver year.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Phoenix database 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 =* *95% +/-5*
☐ ***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:*

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:
The number and percent of waiver claims submitted with the correct rate as specified in the approved waiver document/contracts. N = # of claims using the correct rate; D = total # of claims.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
MMIS Claims Report

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 =* *+/- 5%*
☐ ***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.*

The EVV System is where providers use a toll-free number and/or free mobile application to document service delivery (i.e., respite, nursing, nurse care coordination and pediatric medical day care services). The claim is recorded and compared against service authorizations on file. Claims must meet all criteria to be submitted to Medicaid Management Information System (MMIS) for payment, in which the billing code determines the rate of reimbursement. The state's MMIS ensures that claims submitted via EVV/Mobile application are for current waiver participants, that the service is paid at the appropriate rate and that the waiver participant is Medicaid eligible.

The Phoenix database system automatically ties the needs identified in the assessment to the service plan. This ensures that

any services billed for a waiver participant are identified as a need on the assessment.

b. Methods for Remediation/Fixing Individual Problems

i. *Describe the State's 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.*

Aggregated data is used to identify training needs and areas requiring policy clarification/amendments. Any errors identified by staff are corrected and claims are reprocessed appropriately. Provider trainings are done on an as needed basis. SCDHHS staff training is also done on a periodic basis to ensure the latest policy updates are reviewed.

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 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 Department of Reimbursement Methodology and Policy, with the assistance of the Office of Health Programs, is responsible for the development of waiver service payment rates. SCDHHS allows the public to offer comments on waiver rate changes and rate setting methodology either through the Medical Care Advisory Committee (MCAC) meetings, public notices or through meetings with provider association representatives.

Working collaboratively alongside the waiver provider associations and committees, SMA staff (Program and Reimbursement) continually monitor and gauge the effectiveness of reimbursement rates and methodologies. Historically, annual cost report filings, comparable Medicaid service rates, and surveys of other states' waiver rates were used to validate and substantiate the periodic provider group requests for updates to waiver rates. Due to changing trends in SMA rate development strategies and design as well as CMS guidance in recent years, the SMA has shifted from rate justifications based on cost report data to the construction (rate build-up) of rate models based on market salary data, associated direct operational costs and application of an indirect rate for support costs. When trend rates are applied to provider rates during the rate setting process, the trend factor used is normally the CMS Medicare Economic Index.

Nurse Care Coordination services are provided by licensed nurses with pediatric experience. The rates for this service were established to be comparable to registered nurse service rates in other SCDHHS programs. Specifically, these rates were developed to align these payment rates with RN services provided to children with high levels of need that are available under the State Plan. For Nurse Care Coordination services on or after Jan. 1, 2022, a cost-based assessment of existing provider staffing and operating costs will be considered. The impact of statewide rate increases for nursing services (effective 1-1-20 and 7-1-20) on PMDC rates was considered in comparison to the existing PMDC provider nursing staff salaries.

Respite rates for RN and LPN services were established to ensure comparability with RN and LPN services (non-enhanced) that are available under the State Plan, specifically, home-based private duty nursing services. Unskilled respite rates were developed to be consistent with respite rates in other waivers. The respite rates for RN/LPN services were based on the existing unit cost in the most recently approved waiver and were reviewed during the current renewal cycle (2021).

The Pediatric Medical Day Care rate was developed using a market-based pricing approach. This methodology incorporated a cost-based assessment of existing provider staffing and operating costs. Allowable cost components were identified to reflect costs that are reasonable, necessary, and related to the delivery of the service. Market-based research was performed to inform the development of the assumptions for various cost components. This included input from the current PMDC provider on billable hours, estimated net patient revenue, salary costs, total operating expenses and the hourly reimbursement needed for break-even. Based on inputs from the cost-based assessment from the PMDC provider and actuarial calculations using market-based research, low and high rate scenarios were developed. From this, a mid-point range was calculated which reflects the new rate for PMDC. The unit rate for the PMDC service is established in a three-year service contract. Re-evaluation of the cost assessments and established rates occurs upon renewal, extension or amendment of the service contract.

Environmental modification waiver service rates with the exception of ramps are manually priced based upon the provider's cost estimate. Ramps are priced by the linear foot and participants choose a provider. The State regularly solicits input from providers on the appropriateness of the per foot rate and adjusts this rate based upon changes in lumber costs. There is no single rate for all ramps. Phoenix includes a spreadsheet which gathers data on such things as number of feet of ramp, number of decks, turns, etc. This automatically calculates the cost of the ramp. For all other modifications, competitive bids are solicited and the lowest responsive bid is accepted. Cost is the evaluation criteria for all other modifications. The State does not establish rate minimums or maximums for other modifications. The environmental modification specialist will review bid rates and ask for adjustments if there is no appropriate bid returned based upon the specifications of the job. Home modifications are done by bid. An employee of the SMA provides specifications for all modifications and, through Phoenix, puts them out for bid to all providers covering the geographical area. Providers submit a bid and a winning bid is declared. The case manager authorizes the service at the bid level and the provider uses EVV/Phoenix to bill. The paid amount cannot exceed the winning bid level.

Changes in rate determination methods and rate changes are primarily communicated through the quarterly MCAC (Medical Care Advisory Committee) meetings on an as needed basis as well as monthly IHS conference calls. Further, waiver renewals, amendments, and rate updates are communicated to the public through public notices and subsequent public meetings and webinars. Comments are solicited through these communications. For clarification, the rate for Nurse Care Coordination services was based on a cost build up model driven by RN salaries projected to be experienced

in pediatric care. The compensation statistics used were from SC Office of Human Resources (for state employees) but modified for a percentage of 10% to allow for private sector differential. These rates are not used in any other SC Medicaid program. The rates for RN and LPN Services are the same as those provided under the State Plan.

Funds from the ARP Act, Section 9817 will be temporarily utilized for activities approved in SCDHHS ARPA spending plan.

The Self-Directed Attendant Care rate is determined based upon the salaries of frontline workers of personal care agencies. Personal Care Aide salaries represent a slightly higher rate because there are no benefits provided. The SMA uses market analysis to determine what the private rate is for Attendant Care services. This research consists of an informal process whereby private providers are contacted to inquire about the private pay rate for the same service. The SMA takes this information into consideration when determining rates or adjustments to rates. As appropriate, the SMA will survey agencies for the salaries of frontline workers. Attendant Care services are paid at a fixed rate. This rate includes the hourly rate for the service plus the employee and employer share of taxes and standard deductions.

The SMA publishes Medicaid Bulletins to provide rate information to stakeholders. Bulletins can be accessed by navigating to "Communications" on the Home Screen of the SMA public-facing website. Bulletins are accessed by entering key words in the "Filter Bulletins" field. The rate schedules may also be accessed by navigating to "Providers" on the SMA home screen. Users may select the "Fee Schedules" to access rate information for various SMA-funded services.

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 States claim payment system. For all waiver services, the provider uses the EVV/Mobile application systems to document delivery of services.

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:*

The State now processes all Medically Complex Children Waiver services through the EVV/Mobile application systems. For all claims submitted through these systems, a pre-payment review is conducted. EVV/Mobile application only submits claims to MMIS for services that were prior-authorized by the nurse care coordinator and are included in the participant's service plan. EVV compares services documented by providers to the amount, frequency, and duration prior-authorized by the nurse care coordinator. The claim will submit to MMIS for payment up to the authorized amount in the service plan.

Once the claim is submitted to MMIS, payment is made to the provider only if the participant was Medicaid eligible on the date of service and MMIS shows the participant is enrolled in the waiver program. This is the case for all claims, regardless of whether they are submitted through the EVV system.

The Division of Program Integrity conducts post-payment reviews. They review sample claims and determine if services have been billed as authorized. Whenever a recoupment is identified, the Division of Program Integrity notifies the Financial Department of the SMA who reimburses CMS utilizing the "CMS 64 Summary Sheet."

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:

A financial management services entity (FMS) is used to make payments for participant-directed Attendant care. Weekly data and payments are transmitted from MMIS to the FMS, including a detailed breakdown of each worker's claims. From these transmittals, the FMS collects and processes time worked for each worker, processes payroll, withholds, files and pays all applicable employment-related taxes and insurance. The FMS reimburses providers weekly and transmits this information to Phoenix. Daily, funds received are reviewed and compared to the amount of funds paid.

All waiver providers use Phoenix and/or EVV interface for Medicaid billing. Depending upon the service, this is performed either through in-person visit verification at the participant's residence or through web-based billing. Providers using EVV do so through a telephone line or a smart telephone application when they commence and end services. This input communicates the service type, the worker's identity, specific content noting work completed while providing the service, and any observations about the overall well-being of the participant. Phoenix then compares this with the associated authorization and, if the service is provided as authorized, submits a claim up to the authorized level.

Providers using the EVV web-interface in billing other services use the portal to indicate the date of service and the number of units provided. As with EVV entry, this is compared with the authorized amount and billed to that limit. In both cases, Phoenix submits claims multiple times a week, while providers are paid once weekly. There is a resolution process for providers to use in case of user error or system failure. Providers receive initial training in billing prior to any authorizations of service. In addition, providers have access to online guidance through Phoenix, which describes how to bill and run reports so providers can monitor staff and associated billing activity. There is also made available periodic training for any provider upon request. Additionally, a help desk is available for providers over the telephone as well as through "submitting a problem" via Phoenix.

The participant-directed Attendant service uses a fiscal agent. All documentation of service is completed following noted EVV service guidelines. Payments are applied to the fiscal agent, who makes indicated deductions then remits payment to the Attendant. The SMA receives files on a regular basis indicating payments applied for individuals providing participant-directed services. These are compared with claims reports indicating funds paid to the FMS provider. The SMA outlines staff responsibilities to ensure provider payments are timely and accurate.

☐ ***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:

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:

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

- ( ) ***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 section 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 section 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 section 1915(b)/section 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 section 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 section 1115/section 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 section 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 text box below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of section 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 section 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:*

Do not complete this item.

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	3114.60	59908.67	63023.27	86600.96	19449.55	106050.51	43027.24
2	3250.64	61705.93	64956.57	88332.98	20033.04	108366.02	43409.45
3	7182.60	63557.11	70739.71	90099.64	20634.03	110733.67	39993.96
4	18786.02	57661.00	76447.02	91901.63	21253.05	113154.68	36707.66
5	19355.25	59390.00	78745.25	93739.67	21890.64	115630.31	36885.06

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	3091	3091
Year 2	3091	3091
Year 3	3091	3091
Year 4	3091	3091
Year 5	3091	3091

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.*

The state has projected ALOS based on actual experience from the current waiver period (SFY 2020).

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:*

The state used internal reports for the recent 372 document to provide projections for users, utilization and units. Rates are based upon existing rates with an annual 3% inflation factor for each year of the waiver after Year 1. The Rate Determination Method applied is noted in Appendix I-2-a. The 3% inflation rate for Factor D represents the projected unit cost increase for waiver services. Additionally, the unduplicated participants are estimated to remain flat across waiver years 1-5. As a result, the expenditures presented in Appendix J are projected to increase by approximately 3% per year.

The unit cost for waiver year 1 was updated in J-2-d to reflect the new rates. For subsequent waiver years, the methodology in J-2-c-i was applied to trend forward the waiver estimates.

Based on the utilization of Children's Personal Care in SFY 2023 claims data, we have assumed that 40% of the MCC participants will utilize self-directed Attendant Care, effective October 1, 2024 (three quarters of the way through waiver year 3). The units per user has been set to the assumed maximum allowed units (40 hours per week, or 160 15-minute units per week).

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:*

Internal reports for the recent 372 document were used to provide average annual estimates of participants receiving acute care services. These estimates are based upon existing expenditures with an annual 3% inflation factor for each year of the waiver after Year 1.

Factor D' has been updated to reflect that the MCC utilization of some state-plan only services will shift to the self-directed Attendant Care service starting in October 2024. We have assumed that two thirds of Children's Personal Care utilization and one third of Private Duty Nursing utilization will shift to self-directed Attendant Care.

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:*

Internal reports for medically complex children with hospitalizations were used to determine the factor G estimates. An annual 3% inflation factor was added to each year after year one.

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:*

Internal reporting for factor G' estimates are based on acute care costs for medically complex children with hospitalizations. An annual 3% inflation factor for each year of the waiver after Year 1 was added.

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	
Attendant Care	
Nurse Care Coordination	
Respite	
Environmental Modifications	
Pediatric Medical Day Care	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver.*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. 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	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Attendant Care Total:						**0.00**
Self Directed Attendant Care (effective 10/1/2024)	15 mins	0	0.00	0.01	**0.00**	
Nurse Care Coordination Total:						**7988487.60**
Care Coordination Contact	15 Mins	3091	57.38	33.00	**5852932.14**	
Care Coordination Visit	15 Mins	2862	8.22	54.00	**1270384.56**	
Care Advocate Contact	15 Mins	3091	15.55	18.00	**865170.90**	
Respite Total:						**655365.60**
Skilled Respite	Hourly	175	144.00	23.97	**604044.00**	
Unskilled Respite	15 Mins	88	144.00	4.05	**51321.60**	
Environmental Modifications Total:						**275000.00**
Environmental Modifications	Per Claim	50	1.00	5500.00	**275000.00**	

GRAND TOTAL: 9627221.55

Total Estimated Unduplicated Participants: 3091

Factor D (Divide total by number of participants): 3114.60

Average Length of Stay on the Waiver: 280

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Pediatric Medical Day Care Total:						**708368.35**
Pediatric Medical Day Care	Hourly	107	232.29	28.50	**708368.36**	

GRAND TOTAL: 9627221.55
Total Estimated Unduplicated Participants: 3091
Factor D (Divide total by number of participants): 3114.60
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.

i. Non-Concurrent Waiver. *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. 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	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Attendant Care Total:						**0.00**
Self Directed Attendant Care (effective 10/1/2024)	15 mins	0	0.00	0.01	**0.00**	
Nurse Care Coordination Total:						**8094904.55**
Care Coordination Contact	15 Mins	3091	57.38	33.60	**5959349.09**	
Care Coordination Visit	15 Mins	2862	8.22	54.00	**1270384.56**	
Care Advocate Contact	15 Mins	3091	15.55	18.00	**865170.90**	
Respite Total:						**961200.00**
Skilled Respite	Hourly	175	144.00	35.00	**882000.00**	
Unskilled Respite	15 Mins	88	144.00	6.25	**79200.00**	
Environmental Modifications Total:						**283250.00**
Environmental Modifications	Per Claim	50	1.00	5665.00	**283250.00**	
Pediatric Medical Day Care Total:						**708368.35**
Pediatric Medical Day Care	Hourly				**708368.36**	

GRAND TOTAL: 10047722.90
Total Estimated Unduplicated Participants: 3091
Factor D (Divide total by number of participants): 3250.64
Average Length of Stay on the Waiver: 280

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		107	232.29	28.50		

GRAND TOTAL: 10047722.90
Total Estimated Unduplicated Participants: 3091
Factor D (Divide total by number of participants): 3250.64
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.

i. Non-Concurrent Waiver. *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. 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	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Attendant Care Total:						**11851756.80**
Self Directed Attendant Care (effective 10/1/2024)	15 mins	1236	2080.00	4.61	**11851756.80**	
Nurse Care Coordination Total:						**8338106.41**
Care Coordination Contact	15 Mins	3091	57.38	34.61	**6138484.28**	
Care Coordination Visit	15 Mins	2862	8.22	55.62	**1308496.10**	
Care Advocate Contact	15 Mins	3091	15.55	18.54	**891126.03**	
Respite Total:						**990067.68**
Skilled Respite	Hourly	175	144.00	36.05	**908460.00**	
Unskilled Respite	15 Mins	88	144.00	6.44	**81607.68**	
Environmental Modifications Total:						**291747.50**
Environmental Modifications	Per Claim	50	1.00	5834.95	**291747.50**	
Pediatric Medical Day Care Total:						**729743.68**
Pediatric Medical Day Care	Hourly	107	232.29	29.36	**729743.68**	

GRAND TOTAL: 22201422.07
Total Estimated Unduplicated Participants: 3091
Factor D (Divide total by number of participants): 7182.60
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.

i. Non-Concurrent Waiver. *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. 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	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Attendant Care Total:						**47407027.20**
Self Directed Attendant Care (effective 10/1/2024)	15 mins	1236	8320.00	4.61	**47407027.20**	
Nurse Care Coordination Total:						**8588766.70**
Care Coordination Contact	15 Mins	3091	57.38	35.65	**6322940.33**	
Care Coordination Visit	15 Mins	2862	8.22	57.29	**1347783.92**	
Care Advocate Contact	15 Mins	3091	15.55	19.10	**918042.46**	
Respite Total:						**1019691.36**
Skilled Respite	Hourly	175	144.00	37.13	**935676.00**	
Unskilled Respite	15 Mins	88	144.00	6.63	**84015.36**	
Environmental Modifications Total:						**300500.00**
Environmental Modifications	Per Claim	50	1.00	6010.00	**300500.00**	
Pediatric Medical Day Care Total:						**751616.11**
Pediatric Medical Day Care	Hourly	107	232.29	30.24	**751616.11**	

GRAND TOTAL: 58067601.36

Total Estimated Unduplicated Participants: 3091

Factor D (Divide total by number of participants): 18786.02

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.

i. Non-Concurrent Waiver. *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. 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	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Attendant Care Total:						**48846720.00**
Self Directed Attendant Care (effective 10/1/2024)	15 mins	1236	8320.00	4.75	**48846720.00**	
Nurse Care Coordination Total:						**8846404.77**
Care Coordination Contact	15 Mins	3091	57.38	36.72	**6512717.22**	
Care Coordination Visit	15 Mins	2862	8.22	59.01	**1388248.02**	
Care Advocate Contact	15 Mins	3091	15.55	19.67	**945439.53**	
Respite Total:						**1050449.76**
Skilled Respite	Hourly	175	144.00	38.25	**963900.00**	
Unskilled Respite	15 Mins	88	144.00	6.83	**86549.76**	
Environmental Modifications Total:						**309515.00**
Environmental Modifications	Per Claim	50	1.00	6190.30	**309515.00**	
Pediatric Medical Day Care Total:						**773985.63**
Pediatric Medical Day Care	Hourly	107	232.29	31.14	**773985.63**	

GRAND TOTAL: 59827075.16

Total Estimated Unduplicated Participants: 3091

Factor D (Divide total by number of participants): 19355.25

Average Length of Stay on the Waiver: 280