SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Medically Complex Children (MCC) Waiver Children's Attendant Care

MCC Waiver Administration Team

June 25, 2025

Overview

- Goal and MCC waiver program background
- Referral and Pre-admission screening process
- MEA process
- LOC process
- Enrollment – Initial and Ongoing
- High level overview of each service (Include basic definition and service limits)
  - Nurse Care Coordination
    - Nurse Care Coordinator
    - DME Advocate
    - Care Advocate
  - Respite – Skilled and Unskilled
  - Environmental Modifications
  - Pediatric Medical Day Care
  - Children's Attendant Care
- Transition to OIDD/DDSN waiver programs

Goals

- To provide ongoing continuity of care to children using nurse care coordinators. These coordinators serve as liaisons between waiver participants and all medical and community service providers
- To decrease hospitalizations and emergency room visits. This effort will improve quality of life for waiver participants and be cost-effective

Background

- Established in 2008
- Serves Medicaid-eligible children birth to 21 years of age with chronic physical/health condition(s) expected to last at least 12 months
- Applicants must meet medical criteria and hospital level-of-care
- Eligible children must be residents of South Carolina and qualify for full benefit Healthy Connections Medicaid
- Current census: **2,027***

**Census current as of June 10, 2025*

Referral Process

- Referrals may be made by anyone with knowledge of the medical needs of the applicant.
- Referrals may be made to Centralized Intake online at https://phoenix.scdhhs.gov/cltc_referrals/new or by calling toll-free 888-971-1637
- A pre-admission screening authorization is created for applicants meeting intake criteria

Pre-Admission Screening – Step One

- Nurses employed by a contracted care service organization completes telephonic Medical Eligibility Assessment (MEA) Tool to determine if applicant meets criteria for the in-person level of care assessment
- Completed for applicants in the community and applicants within 5 business days of discharge from the hospital
- Nurse schedules an in-person level of care assessment for applicants meeting minimum MEA criteria

Pre-Admission Screening – Step Two

- Level of care assessment must be completed in the applicant's home*
- Applicant must meet hospital level of care
- Can be Skilled or Intermediate

**Initial level of care may be completed in the hospital, but an assessment must also be completed in the home environment*

Enrollment – Initial and Ongoing Requirements

- A person-centered service plan (PCSP) is developed for applicants meeting initial hospital level of care
- The PCSP is updated as participant needs change
- Ongoing enrollment requires an in-person semi-annual MEA and an annual level of care
- Participants must continue to meet MEA and LOC criteria
- Ongoing waiver program eligibility must be determined during a face- to-face visit

Services - Nurse Care Coordination

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

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

Services - Respite

- **Respite*** services provided to participants unable to care for themselves and furnished on a short-term basis because of the absence or need for relief of those persons who normally provide care for the participant. Can be skilled or unskilled
- 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
- Respite may be provided up to 12 hours per month
- *Implementation is pending*

Services – Environmental Modifications

- **Environmental Modifications** 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.
- Adaptations include the installation of wedges/ramps and grab-bars, widening of doorways, modification of bathroom facilities, etc.
- There is a $7,500 lifetime monetary cap per waiver participant

Services – Pediatric Medical Day Care

- **Pediatric Medical Day Care** services furnished on an hourly basis, or as specified in the person-centered service plan, in a licensed, integrated, community-based setting, encompassing both health and social services needed to ensure the optimal functioning of the participant. Meals provided as a part of these services shall not constitute a full nutritional regiment (3 meals per day).
- Services are limited to children ages birth – 6
- Service may not exceed 45 hours per week

Services – Children's Attendant Care (Self-Directed)

- Children's Attendant Care (CAC)* services are limited to children enrolled in the Medically Complex Children waiver only
- Provides extraordinary hands-on care in the home for children who require help with at least two of the seven activities of daily living.
- CAC is a self-directed service model and can be used instead of an in-home care agency and personal care aide (PCA). It allows for eligible parents, relatives or guardians to be paid hourly to deliver the extraordinary care their child needs for day-to-day activities
- Children's attendant caregivers may provide up to 40 hours of paid care
- **Implementation is pending*

Transitions from MCC to OIDD/DDSN Waiver

- OIDD/DDSN Case Manager coordinates transition date via email with MCC Nurse Care Coordinator and copies SCDHHS MCC and OIDD/DDSN Admin Teams
- SCDHHS MCC Admin Team will provide OIDD/DDSN Case Manager with all open authorizations/waiver supports such as state plan CPCA, CPDN, and IS authorizations along with the Provider information and total units authorized
- OIDD/DDSN Case Manager will send notification to SCDHHS MCC Admin Team with confirmation of transfer date
- MCC Nurse Care Coordinator will coordinate with SCDHHS MCC Admin Team to close all Phoenix waiver supports, application(s) and terminate RSPs

Transitions from CPDN to Community Supports Waiver

- If participant receives Children's Private Duty Nursing (CPDN) services and is wanting to transition to the Community Supports (CSW) waiver this is not a CSW service
- For children enrolling in the Community Supports waiver who continue to need nursing, the CPDN only referral must be made in advance of the transition date due to processing time
- If it is known the child doesn't qualify for CPDN per the checklist, that service will need to terminate when the MCC application is terminated, and this termination notification will be included in the notification form sent to the Authorized Representative

Transitions from CPDN Only to OIDD/DDSN

- OIDD/DDSN Case Manager will notify SCDHHS MCC Waiver Admin Team of transition to OIDD/DDSN waiver
- SCDHHS MCC Waiver Admin Team will provide OIDD/DDSN Case Manager with CPDN open authorizations/waiver supports along with the Provider information and total units authorized
  - If the CPDN participant also receives any other services such as Children's Personal Care Aide (CPCA) or Incontinent Supplies (IS) SCDHHS MCC Waiver Admin Team will provide the Case Manger information for those services along with the authorizations.
- Once the OIDD/DDSN Case Manager will send notification to SCDHHS MCC Waiver Admin Team with confirmation of transfer date
- SCDHHS MCC Waiver Admin Team will close out the CPDN authorization and the CHPC RSP

Children's Private Duty Nursing Program (CPDN) State Plan Information

- Children's Private Duty Nursing Program (CPDN) is a State Plan service and **NOT** a Waiver.
- To be eligible must be under the age of twenty-one (21)
- The individual must have an illness or disability, which requires ongoing skilled observation, monitoring and judgment; such as:
  - Chronic neurological impairment
  - Respiratory impairment
  - Frequent monitoring of vital signs
  - Nutritional impairment
  - Impaired immune status
  - Integumentary instability
  - Genitourinary/gastrointestinal interventions

Questions