Application for

Section 1915(b) (4) Waiver
Fee-for-Service
Selective Contracting Program

v1.0

Table of Contents

Facesheet 3

Section A – Waiver Program Description 4

Part I: Program Overview
- Tribal Consultation 4
- Program Description 4
- Waiver Services 5
- A. Statutory Authority 5
- B. Delivery Systems 6
- C. Restriction of Freedom-of-Choice 7
- D. Populations Affected by Waiver 8

Part II: Access, Provider Capacity and Utilization Standards
- A. Timely Access Standards 9
- B. Provider Capacity Standards 11
- C. Utilization Standards 12

Part III: Quality
- A. Quality Standards and Contract Monitoring 13
- B. Coordination and Continuity-of-Care Standards 16

Part IV: Program Operations
- A. Beneficiary Information 17
- B. Individuals with Special Needs 17

Section B – Waiver Cost-Effectiveness and Efficiency 17

Application for Section 1915(b) (4) Waiver Fee-for-Service (FFS) Selective Contracting Program

Face Sheet

The **State** of _South Carolina _ requests a waiver/amendment under the authority of section 1915(b) of the Act. The Medicaid agency will directly operate the waiver.

The **name of the waiver program** is Palmetto Coordinated System of Care__.
(List each program name if the waiver authorizes more than one program.).

Type of request. This is:
_X__ an initial request for new waiver. All sections are filled.
___ a request to amend an existing waiver, which modifies Section/Part ____
___ a renewal request

Section A is:

___ replaced in full
___ carried over with no changes
___ changes noted in **BOLD**.

Section B is:

___ replaced in full
___ changes noted in **BOLD**.

Effective Dates: This waiver/renewal/amendment is requested for a period of _5__ years beginning **__08/01/2020__**and ending **__7/30/2025__**.

State Contact: The State contact person for this waiver is _Janice Bailiff _ and can be reached by telephone at (803) 898-2043, or fax at (803) 255-8204, or e-mail at _Janice.Bailiff@scdhhs.gov_.

Section A – Waiver Program Description

Part I: Program Overview

Tribal Consultation:
Describe the efforts the State has made to ensure that Federally recognized tribes in the State are aware of and have had the opportunity to comment on this waiver proposal.

South Carolina Department of Health and Human Services 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 this Medicaid 1915(c)waiver request to CMS. This notice was made February 9, 2016 and an update was given on May 9, 2017. Tribal Governments received notification of the State's intent to submit a revised version of this request on February 25, 2020. Input had not been received at the conclusion of either 60-day public input process periods.

Program Description:
Provide a brief description of the proposed selective contracting program or, if this is a request to amend an existing selective contracting waiver, the history of and changes requested to the existing program. Please include the estimated number of enrollees served throughout the waiver.

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

The purpose of 1915(c) waiver is to provide home and community-based supports and services to children with mental illness who would otherwise be served in inpatient general and psychiatric hospitals. Families and youth are offered the choice of behavioral health services and supports to permit the youth to remain in, or return to, the least restrictive environment-preferably their homes. To be eligible, a potential waiver participant must meet the inpatient level of care and meet all Medicaid financial requirements.

The following chart provides an estimate of the number of children projected to be served for each year of the program.

Annual Period	From	To	Projected Number of Participants
Year 1	August 1, 2020	July 31, 2021	240
Year 2	August 1, 2021	July 31, 2022	290
Year 3	August 1, 2022	July 31, 2023	360
Year 4	August 1, 2023	July 31, 2024	420
Year 5	August 1, 2024	July 31, 2025	480

The following services will be provided to PCSC waiver program participants:

- High Fidelity Wraparound
- Respite
- Individual Directed Goods and Services

High Fidelity Wraparound

High Fidelity Wraparound (HFW) is a team-based approach to caring for families with complicated needs. The function of performing wraparound facilitation is to identify who should be involved in producing a community-based, person-centered plan to meet the needs of the participant. Those identified family, extended family and other community members comprise the participant and family team and play a vital role in the development of the person-centered plan. The wraparound facilitator guides the person-centered plan development process, assures that waiver rules are followed and is responsible for reassembling the team when subsequent person-centered plan review and revision are needed. Reassembling happens with warranted changes in the participant's circumstances. The wraparound facilitator emphasizes building collaboration and coordination among family-identified caretakers, service providers and other formal and informal community resources. The participant and family team with the facilitator to perform the four functions of home and community-based services (HCBS) care management: assessment, person-centered planning, referral to services and monitoring of health and welfare and service delivery. Wraparound coordination with other child serving systems should occur as needed. All coordination must be documented in the participant's medical record. The high-fidelity entity must ensure that all participants and family team members adhere to the HCBS requirements found at 42 CFR 441.301(c). Participant and family teams receive regular clinical supervision by a Licensed Practitioner of the Healing Arts employed by the HFW entity. Wraparound coaches and trainers credentialed by the National Wraparound Implementation

Center (NWIC) must be members of HFW teams. Further, HFW teams must demonstrate continued use of evidence-based wraparound standards as approved by SCDHHS through ongoing participation in wraparound fidelity monitoring.

Respite

Respite care includes services provided on a short-term, planned or emergency basis, and offers relief to a participant's unpaid caregiver who is unable to provide services to the participant. This service will be provided to meet the participant needs, as per the person-centered plan. Participants are encouraged to receive respite in the most integrated and cost-effective settings.

Respite services may include the following activities:
• Assistance with the participant's social interaction, use of natural supports and typical community services available to all people and participation in volunteer activities.
• Activities to improve the participant's capacity to perform or assist with activities of daily living and instrumental activities of daily living.
• Onsite modeling of behavior, behavior support, intensive behavior episode intervention, training, cueing, and/or supervision.
• Camp funding for summer camp that provides the needed safeguarding services and supports to achieve the person's valued outcomes, as per the person- centered plan. Camps can either be focused on supporting youth with disabilities or camps that are available to the general public.

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

Individual Directed Goods and Services

Individual Directed Goods and Services are services, equipment or supplies not otherwise provided through this waiver or through the Medicaid State Plan that address an identified need in the person-centered plan in service of improving and maintaining the participant opportunities for full membership in the community. Individual Directed Goods and Services must meet the following requirements: the item or service decreases the need for other Medicaid services; AND/OR promotes inclusion in the community; AND/OR increases the participant's safety in the home environment; AND funds to purchase the item or service is not available through another source. Experimental or prohibited treatments are excluded. Individual Directed Goods and Services must be documented in the person-centered plan.

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

Allowable Categories that cannot exceed published fees:

Training/Coaching Classes that relate to a person's valued outcomes, as per their person-centered plan. Classes must be related to a habilitative need in the participant's person-centered plan and cannot be for recreational purposes. Classes must be non-credit bearing; participant directed goods and services funding is for non-matriculating students.

Community Transition Services may be used by waiver transition-aged (18 – 21) participants transitioning from institutional or another provider-operated setting to the community to establish a private residence. The service may not be used to pay room and board. Allowable expenses must be non-recurring (i.e. bedroom linen, mattresses, etc.) and required to establish a household where the participant is solely responsible for his or her living expenses. The purchase of goods and services from this category are only allowable when the item cannot be funded through another source. Community Transition Services do not include monthly rental or mortgage expense; food, regular utility charges; and/or household appliances or items that are intended for purely diversional/recreational purposes. The need for Community Transition Services must be clearly identified on the on the person-centered plan of care.

Chore Service may be used when identified during the service plan development process. This service may be used to maintain the home in a clean, sanitary and safe environment. These services are provided only when neither the participant nor anyone else in the household is capable of performing or financially providing for them, and where no other relative, caregiver, landlord, community/volunteer agency, or third party payor is capable of or responsible for their provision. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, is examined prior to any authorization of service.

Transition Programs for Individuals with Behavioral Health Diagnoses such as tuition for non-credit bearing transition programs for participant with behavioral health diagnoses who have already completed their educational program (i.e., 'aged out'). The coursework must address a person's valued outcomes, as per the person-centered plan and address skill building and employment outcomes. Programs may not be provided in locations certified by the Department of Mental Health. The program cannot be funded by ACCESS-VR, IDEA or other funding sources. Services are time-limited and cannot exceed a two-year timeframe. No room and board costs are fundable. All staff, volunteers and trainers are screened for criminal background and excluded provider status. The goods and services purchased under the authority must be documented and clearly linked to an assessed participant need established in the service plan.

Waiver Services:

Please list all existing State Plan services the State will provide through this selective contracting waiver.

This waiver only seeks to selectively contract to provide High Fidelity Wraparound (HFW). It is not an existing State Plan service. The State does not seek to selectively contract to provide an existing service in the State Plan.

A. Statutory Authority

1. **Waiver Authority.** The State is seeking authority under the following subsection of 1915(b):

   _X_ **1915(b) (4) - FFS Selective Contracting program**

2. **Sections Waived.** The State requests a waiver of these sections of 1902 of the Social Security Act:

   a.___ **Section 1902(a) (1) - Statewideness**
   b.___ **Section 1902(a) (10) (B) - Comparability of Services**
   c. X__ **Section 1902(a) (23) - Freedom of Choice**
   d.___ **Other Sections of 1902** – (please specify)

B. Delivery Systems

1. **Reimbursement.** Payment for the selective contracting program is:

   ____ the same as stipulated in the State Plan
   __X__ is different than stipulated in the State Plan (please describe)

   High Fidelity Wraparound is not a State Plan service. With the approval of the 1915(c) waiver, the HFW entity will directly bill Medicaid on a per member per month basis for enrolled participants. Billing will be initiated by the monthly child and family team meeting. The child and family team is a multi-disciplinary team trained in High Fidelity Wraparound including: a wraparound facilitator, participant, family, providers, and other persons that the participant and family choose to participate.

   At the child and family team meetings, the team determines what services are needed to maintain the participant in the home. Information gathered from the initial assessment is used to support this process. The person-centered plan includes a crisis plan that clearly signifies the protocol and responsibility for handling crises, including after-hour calls. The person-centered plan must contain all items required in the HCBS regulations. Once the child and family team facilitates the person-centered plan, the team signs that they were present and they agree with the plan of care. Then the family/participant select providers from a list of qualified providers. When the person-centered plan has been developed and signed by the wraparound facilitator, the family, participant, and the providers, the wraparound facilitator submits the person-centered plan of care to SCDHHS for final approval. Once approved, the wraparound facilitator coordinates with the family and service providers to begin services.

   The billing validation process to produce a claim for federal financial participation follows. Upon submission of a claim to the Medicaid Management Information System (MMIS), payment is made to the provider only if the participant was Medicaid eligible on the date of service and there was an indicator in MMIS that the participant is enrolled in the waiver program.

The Division of Program Integrity conducts post-payment reviews. These reviews sample claims and determine if services have been billed as authorized and are included in the participant service plans.

2. **Procurement**. The State will select the contractor in the following manner:

___ **Competitive** procurement
___ **Open** cooperative procurement
___ **Sole source** procurement
_X_ **Other** (please describe)

SCDHHS seeks to selectively contract with the Continuum of Care to provide High Fidelity Wraparound intensive care coordination services. Based on national research for children's system of care, SCDHHS will only contract with entities employing High Fidelity Wraparound supervisors and coaches credentialed by the National Wraparound Implementation Center (NWIC).

Further, High Fidelity Wraparound Teams with credentialed supervisors and coaches must demonstrate continued use of evidence-based wraparound standards as approved by SCDHHS through ongoing participation in wraparound fidelity monitoring. SCDHHS will not accept any willing provider for this high intensity level of service. The High Fidelity entity must ensure that all child and family team members adhere to the HCBS requirements found at 42 CFR 441.301(c).

C. Restriction of Freedom of Choice

1. **Provider Limitations**.

_X__ Beneficiaries will be limited to a single provider in their service area.
____ Beneficiaries will be given a choice of providers in their service area.

Beneficiaries will be given a choice of Wraparound Facilitators in their service area. However, because of the difficulty of obtaining and maintaining this certification, it is only expected that one or two providers at most will be available in the State of South Carolina. The program must guarantee the vendors enough volume of service to justify the vendors undergoing and maintaining the expense of the certification. It is expected that one vendor will primarily serve children who are in SC Department of Social Services custody. The second vendor will primarily serve children who are in their parent's or caregiver's custody. When possible, beneficiaries will be given a choice of wraparound facilitators within each vendor.

(NOTE: Please indicate the area(s) of the State where the waiver program will be implemented)

Continuum of Care is a state-wide program serving each of South Carolina's 46 counties. Continuum has several office locations throughout the state.

2. **State Standards**

Detail any difference between the state standards that will be applied under this waiver and those detailed in the State Plan coverage or reimbursement documents.

With the approval of the PCSC 1915(c) home and community-based waiver, High Fidelity Wraparound will be a new service covered through the waiver authority. The High Fidelity Wraparound provider will be required to adhere to all current SCDHHS standards for Medicaid providers.

D. Populations Affected by Waiver

(May be modified as needed to fit the State's specific circumstances)

1. **Included Populations**. The following populations are included in the waiver:

___ Section 1931 Children and Related Populations
___ Section 1931 Adults and Related Populations
___ Blind/Disabled Adults and Related Populations
___ Blind/Disabled Children and Related Populations
___ Aged and Related Populations
___ Foster Care Children
___ Title XXI CHIP Children
_X_ Other

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

2. **Excluded Populations.** Indicate if any of the following populations are excluded from participating in the waiver:

___ Dual Eligibles
___ Poverty Level Pregnant Women
___ Individuals with other insurance
___ Individuals residing in a nursing facility or ICF/MR
___ Individuals enrolled in a managed care program
___ Individuals participating in a HCBS Waiver program
___ American Indians/Alaskan Natives
___ Special Needs Children (State Defined). Please provide this definition.
___ Individuals receiving retroactive eligibility
_X__Other (Please define):

- Any person who does not meet the targeting and needs-based criteria specified in the Included Populations section above.

Part II: Access, Provider Capacity and Utilization Standards

A. Timely Access Standards

Describe the standard that the State will adopt (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State has adopted) defining timely Medicaid beneficiary access to the contracted services, *i.e.,* what constitutes timely access to the service?

1. How does the State measure (or propose to measure) the timeliness of Medicaid beneficiary access to the services covered under the selective contracting program?

   Service provision under this High Fidelity Wraparound selective contracting program begins with a brief screening performed by SCDHHS waiver staff. The brief screening tool determines if the applicant meets targeting criteria for a referral to the Continuum of Care (COC) for a waiver level of care (LOC) assessment. COC verifies information obtained during the brief screen, schedules and conducts the LOC assessment. SCDHHS is notified when the LOC is complete. If the applicant meets the LOC threshold, a provisional plan of care (crisis plan) or person-centered plan has been developed and financial eligibility has been determined, SCDHHS staff will enroll the applicant in the waiver. SCDHHS makes the final waiver enrollment determination. LOC referrals, LOC assessment scores, clinical recommendations and plans of care are recorded and monitored in the electronic Phoenix case management system.

   SCDHHS staff immediately refer applicants failing to meet targeting criteria for LOC assessment to available resources. COC staff immediately refer applicants failing to meet LOC threshold to within agency non-waiver services or an appropriate service referral to an available non-waiver service in the community. Non-waiver service referrals are documented in the Phoenix system.

The following measures will be collected as part of the state's HCBS assurances monitoring plan:

- Average number of days from being screened in by SCDHHS to referral to the Continuum of Care
- Average number of days to become Medicaid eligible if not eligible at time of brief screen call
- Number of applicants who received a LOC within specified days
- Number of plans of care completed within 30 days of LOC

2. Describe the remedies the State has or will put in place in the event that Medicaid beneficiaries are unable to access the contracted service in a timely fashion.

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

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

   When issues/problems/concerns are discovered by SCDHHS through informal processes, the responsible party is contacted by SCDHHS staff. SCDHHS staff identifies the problem, makes the responsible party aware of the problem and ensures that they have appropriate information to correct the problem. If SCDHHS deems the problem/issue/concern to cause imminent danger to the waiver operations or participant, SCDHHS ensures that immediate action is taken to protect the health and welfare of the participant, issues a formal notice of deficiency, and notifies the responsible party. If the issue/problem/concern is of a less serious nature, SCDHHS staff documents the contact and the request for correction to ensure that there is timely and appropriate follow up. The responsible party is given an opportunity to

correct the problem informally and submit corrections to SCDHHS staff. If the problem is not addressed in a timely way, SCDHHS staff formally issues a statement of deficiency requiring a corrective action plan. Once written notification is received, the CAP must be submitted within 30 days to SCDHHS. The corrective action plan addresses both immediate problems and identifies how the problems will be avoided in the future. SCDHHS reviews corrective action plans to ensure that they address the underlying issues/concerns. Failure to submit and implement a corrective action plan may result in being excluded from Medicaid.

B. Provider Capacity Standards

Describe how the State will ensure (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State has ensured) that its selective contracting program provides a sufficient supply of contracted providers to meet Medicaid beneficiaries' needs.

1. Provide a detailed capacity analysis of the number of providers (e.g., by type, or number of beds for facility-based programs), or vehicles (by type, per contractor for non-emergency transportation programs), needed per location or region to assure sufficient capacity under the selective contracting program.

   Upon program go-live, the State's current High Fidelity Wraparound entity, the Continuum of Care (COC), will be available to support the PCSC program initially with a second added as soon as the provider is able to obtain national accreditation. Taking into consideration the projected estimate of PCSC participants in the first year of program implementation and the tasks to be performed, we believe this initial provider capacity is sufficient and will allow for a maximum 1:10 HFW facilitators to participant ratio. There will be a need for another HFW entity that SCDHHS contracts with that specializes in children in the custody of the SC Department of Social Services and a contractor will be added for that population as soon as it is available.

2. Describe how the State will evaluate and ensure on an ongoing basis that providers are appropriately distributed throughout the geographic regions covered by the selective contracting program so that Medicaid beneficiaries have sufficient and timely access throughout the regions affected by the program.

   SCDHHS will monitor the adequacy of High Fidelity Wraparound capacity through the HCBS assurance performance measures:

   - Number and percent of person-centered plans updated every six months.
   - Number and percent of person-centered plans updated as participants needs change.

The Phoenix case management system captures county and regional data staff resource and participant data. This capacity allows the State to monitor enrollment and service provision statewide.

C. Utilization Standards

Describe the State's utilization standards specific to the selective contracting program.

1. How will the State (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State) regularly monitor(s) the selective contracting program to determine appropriate Medicaid beneficiary utilization, as defined by the utilization standard described above?

   SCDHHS believes that the availability of the High Fidelity Wraparound benefit will assist PCSC participants in gaining access to needed services and supports. SCDHHS will review service utilization and performance as part of its ongoing monitoring functions through the following HCBS assurances:

   - Number and percent of newly enrolled participants whose person-centered plans address their needs identified in the assessment.
   - Number and percent of newly enrolled participants whose person-centered plans address their personal goals identified in the assessment.
   - Number and percent of existing participants whose person-centered plans address their needs identified in the assessment.
   - Number and percent of existing participants whose person-centered plans address their personal goals identified in the assessment.
   - Number and percent of participants who received the service type identified in the person-centered plan.
   - Number and percent of participants who received services as identified in the person-centered plan.
   - Number and percent of participants who received services in the amount as identified in the person-centered plan.
   - Number and percent of participants who received services in accordance with the frequency identified in the person-centered plan.
   - Number and percent of participants who received services in accordance with the duration identified in the person-centered plan.

2. Describe the remedies the State has or will put in place in the event that Medicaid beneficiary utilization falls below the utilization standards described above.

   SCDHHS staff conduct performance reviews on providers to ensure that administrative functions are being carried out as required. If concerns are found with

administrative functions, SCDHHS notifies the provider and requests a plan of correction. SCDHHS provides additional oversight in areas of concern until the provider has completed a plan of correction and demonstrated appropriate administrative performance.

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

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

Part III: Quality

A. Quality Standards and Contract Monitoring

1. Describe the State's quality measurement standards specific to the selective contracting program.

a. Describe how the State will (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State):

   i. Regularly monitor(s) the contracted providers to determine compliance with the State's quality standards for the selective contracting program.

   A strong High Fidelity Wraparound benefit will be critical to the success of PCSC. As a result, several quality standards will be implemented to determine the effectiveness of the benefit, including but not limited to:

   - Proportion of HFW providers that meet training requirements in the waiver
   - Number and percent of HFW providers that continue to meet HCBS enrollment requirements.
   - Number and percent of HFW providers that meet initial enrollment requirements prior to providing waiver services.
   - Number and percent of new HCBS provider applicants that meet initial licensure and/or certification enrollment requirements.
   - Number and percent of existing HCBS providers that continue to meet licensure and/or certification enrollment requirements at re-enrollment or review.
   - Number and percent of Continuum of Care staff who meet High Fidelity Wraparound (HFW) training requirements. Number and percent of enrolled HCBS providers completing annual background/registry check waiver requirements.
   - Performance measures that address the important functions performed by HFW facilitators such as:
     - Number and percent of participants/responsible parties notified of their rights to choose waiver services and/or qualified providers when available.
     - Number and percent of service plans that involved participants and/or responsible parties in the development process during the waiver year.

   ii. Take(s) corrective action if there is a failure to comply.

   As noted previously, SCDHHS has several tools available in its tool kit to address an HFW entity's failure to comply with requirements.

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

be avoided in the future. SCDHHS reviews corrective action plans to ensure that they address the underlying issues/concerns. Failure to submit and implement a corrective action plan may result in being excluded from Medicaid.

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

2. Describe the State's contract monitoring process specific to the selective contracting program.

    a. Describe how the State will (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State):

        i. Regularly monitor(s) the contracted providers to determine compliance with the contractual requirements of the selective contracting program.

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

        ii. Take(s) corrective action if there is a failure to comply.

    As noted previously, SCDHHS has several tools available in its tool kit to address a HFW entity's failure to comply with requirements.

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

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

B. Coordination and Continuity of Care Standards

Describe how the State assures that coordination and continuity of care is not negatively impacted by the selective contracting program.

SCDHHS will monitor the overall effectiveness of the PCSC program, including the extent to which selective contracting has a negative impact on coordination and continuity of care.

Part IV: Program Operations

A. Beneficiary Information

Describe how beneficiaries will get information about the selective contracting program.

Young adults or families of children with significant behavioral health needs receive information regarding High Fidelity Wraparound services through the Palmetto Coordinated System of Care stakeholder network as described in the Public Input section of the 1915 (c) waiver application.

B. Individuals with Special Needs.

_X__ The State has special processes in place for persons with special needs (Please provide detail).

The PCSC program, by design, targets only children with special needs – those at risk for out of home placement without receiving the home and community-based services.

Section B – Waiver Cost-Effectiveness & Efficiency

Efficient and economic provision of covered care and services:

1. Provide a description of the State's efficient and economic provision of covered care and services.

   SCDHHS seeks to selectively contract with the Continuum of Care to provide High Fidelity Wraparound services to participants up to age 21 with significant behavioral health challenges who would otherwise be treated for psychiatric conditions in inpatient settings. Research has shown that effective home and community-based services can be less costly and provide better outcomes for participants and their families. High Fidelity Wraparound is an integral service in many national systems of care. In South Carolina, the Continuum of Care is the only entity that employs Wraparound coaches and trainers credentialed by the National Wraparound Implementation Center (NWIC). Further, the CoC High Fidelity Wraparound Teams demonstrate continued use of evidence-based wraparound standards through ongoing participation in wraparound fidelity monitoring. As such, SCDHHS will not accept any willing provider for this high intensity level of service.

   Application for this waiver is based in part on an upsurge in costly, repeated inpatient psychiatric hospitalizations. The implementation of this waiver has the potential to significantly reduce expenditures for this population, while at the same time providing more effective services.

   The SCDHHS, Bureau of Reimbursement Methodology and Policy, is responsible for the development of waiver service payment rates. The SCDHHS allows the public to offer comments on waiver rate changes and rate setting methodology either through Medical Care Advisory Committee meetings, public hearings, or through meetings with association representatives. Waiver service rates are established based upon the projected costs of the service to be provided. SCDHHS, Bureau of Reimbursement Methodology perform financial

reviews to ensure that funding provided by the South Carolina General Assembly was appropriately expended by providers of these services. Except as otherwise noted in the State Plan, the State-developed fee schedule is the same for both governmental and private providers and the fee schedule and any annual/periodic adjustments to the fee schedule are published on the State's website at: https://www.scdhhs.gov/resource/fee-schedules. The fee schedule rate for the High Fidelity Wraparound service was developed using a market-based pricing approach. This methodology includes a review of the service definition, applicable South Carolina regulations, provider qualifications and licensure requirements, required training and certification, staffing requirements and discussions regarding the vision and expectations for service delivery. Allowable cost components were identified to reflect costs that are reasonable, necessary and related to the delivery of service under the 1915(c) waiver. Market-based research was performed to inform the development of the assumptions for the various cost components, along with discussions regarding the State's expectations of service delivery, and these assumptions were then used to model rates for each service. The Bureau of Labor Statistics was the primary data source utilized. Actual provider costs were not used in the development of the fee schedule rates or the development of the modeling assumptions. We have provided more detail below on the sources reviewed, cost components considered, and assumptions used to develop the fees for the 1915(c) waiver services. The State compared the fees developed under the market-based approach to fees in place for similar services in the former CHANCE waiver and other states.

High Fidelity Wraparound (HFW) uses a monthly unit of service. It is delivered by an unlicensed bachelor's level professional with a supervisor who has a bachelor's or master's degree. HFW is an evidence-based practice requiring extensive training, certification and on-going monitoring. While there are no tiered rates, the evidence-based services reflect higher costs of providing the services in fidelity with the national practices including certification, more extensive training, lower caseloads, more travel, and higher provider qualifications. Practitioners, on average, are expected to travel 50 miles a day.

The following list outlines the major components of the market-based approached and assumptions modeled in the fee schedule development process.

- Direct expenses – Direct care salary expenses were taken from Bureau of Labor Statistics (BLS) wage survey for the type of staff required to deliver the services as indicated in the service definitions. The positions vary by service, but generally include counselors, home care aides, psychologists, social workers, and social and/or human service assistants. The hourly salary assumptions ranged from $9 to $52 per hour based on the service and applicable education requirements.
- Employee Related Expenses (ERE) –This category includes ERE the provider is responsible for on behalf of the staff hired to deliver, or oversee the delivery of, the waiver services. This includes items such as the employer's portion of health insurance, worker's compensation, employer taxes (FUTA/SUTA and FICA), disability insurance and paid time off. These assumptions were based on market research from publicly available sources such as BLS as well as discussions with SC DHHS.
- Program-Related expenses – This category includes salary expense for supervisory staff or other program specialists as defined by the service. It also includes expenditures incurred by the provider through the delivery of the service that are not directly billable.

This methodology includes consideration for employee training and certification, staff travel and supply costs, as required by service.

- Non-Benefit expenses – This category includes consideration for general administrative expenses such as administrative staff salaries, administrative building costs, insurance and IT needs. This assumption was established at 10% of overall costs for all services.
- Productivity – These assumptions were built based on productivity expectations for staff delivering the service. A unit of service is defined according to the Healthcare Common Procedure Coding System (HCPCS) approved code set consistent with the National Correct Coding Initiative. While there are no tiered rates, the High Fidelity Wraparound service reflects the higher costs of providing the service in fidelity with the national practices including certification, more extensive training, lower caseloads, more travel, and higher provider qualifications.

The waiver service rates are not updated annually. The State will monitor rate sufficiency using the following techniques and amend the waiver if a rate methodology change is warranted. To monitor for rate sufficiency, the following approaches will be taken under the future waiver period with each waiver renewal; any time an access complaint is received from a provider or beneficiary; or if there is a lack of provider capacity for a service needed by a child:

- Analyze and incorporate feedback from stakeholders. This approach includes evaluating feedback from individuals, families, independent case managers, advocacy groups and providers about the adequacy of direct service providers and collecting data on fair hearings, complaints and grievances related to lack of providers.
- Collect evidence from QIS D, sub-assurance d – This approach includes review of evidence related to the performance measures outlined in QIS D, sub-assurance d, which reviews whether services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the person-centered plan. This evidence includes the specific performance measure that assess whether services are delivered as outlined in the service plans by qualified individuals. The review starting in year four of the past waiver includes determining the reasons that individuals are not receiving services in accordance with the service plan.
- Measure changes in provider capacity – This approach includes measuring the change in the number of the new providers and these providers' capacity as well as service utilization of enrollees and comparing the capacity and service utilization information to the previous years' data.

2. Project the waiver expenditures for the upcoming waiver period.
   Cost projection trend rates were established based on the State's historic CHANCE waiver and experiences from other states' waiver programs with similar services. For years 2 through 5, unit utilization was trended forward using a 2% annual inflation factor.

   Year 1 from: __08/01/2020__ to _7/31/2021_

   Trend rate from current expenditures (or historical figures): ___2_____%

   High Fidelity Wraparound

Projected pre-waiver cost $0
Projected Waiver cost $2,224,800
Difference: $2,224,800

Year 2 from: _8/01/2021__ to _7/31/2022___

Trend rate from current expenditures (or historical figures): ___2_____%

High Fidelity Wraparound
Projected pre-waiver cost $0
Projected Waiver cost $2,781,000
Difference: $2,781,000

Year 3 (if applicable) from: _08/01/2022__ to 7/31/2023__
(*For renewals, use trend rate from previous year and claims data from the CMS-64*)

Unit costs for years 3-5 were trended forward using a 2.0% annual inflation factor, using the Mid-Atlantic Consumer Price Index (CPI) inflation factor for similar services from 2012 which the State believes is representative of the projected time periods in the waiver.
http://www.bls.gov/regions/mid-atlantic/data/consumerpriceindexhistorical1967base_us_table.htm

High Fidelity Wraparound
Projected pre-waiver cost $0
Projected Waiver cost $3,337,200
Difference: $3,337,200

Year 4 (if applicable) from: _08/01/2023_ to 7/31/2024___
(*For renewals, use trend rate from previous year and claims data from the CMS-64*)

High Fidelity Wraparound
Projected pre-waiver cost $0
Projected Waiver cost $3,893,400
Difference: $3,893,400

Year 5 (if applicable) from: _08/01/2024__ to 7/31/2025___

(*For renewals, use trend rate from previous year and claims data from the CMS-64*)

High Fidelity Wraparound

Projected pre-waiver cost	$0
Projected Waiver cost	$4,449,600
Difference:	$4,449,600