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OVERVIEW

The Community Alternatives to Psychiatric Residential Treatment Facilities (PRTF) Demonstration Grant Program was authorized under the Deficit Reduction Act of 2005, to provide a limited number of states with the opportunity to develop a five-year demonstration program that will help states provide home and community-based interventions to youth who are eligible for PRTF level of care.

South Carolina Medicaid program was one of nine states that was awarded grant funds to participate in a PRTF demonstration waiver, which extended from October 1, 2007 until September 30, 2012. The waiver, which is known as Children's Health Access in Community Environments (CHANCE), provided home- and community- based assistance and services to participants, ages four to 19, who were diagnosed with Serious Emotional Disturbance (SED). These participants were placed, or at risk for placement, in a PRTF. In an effort to sustain the waiver beyond September 30, 2012, South Carolina applied for a waiver renewal, which would allow enrolled participants an opportunity to continue their home- and community- based services past the end of the demonstration period. The Centers for Medicare and Medicaid Services (CMS) approved South Carolina's 1915(c) PRTF Alternative CHANCE Waiver renewal request, so that participants, who are enrolled in the waiver after October 1, 2012, can continue utilizing the home and community-based services. As participants are discharged from the waiver, new slots will **not** be added. The PRTF Alternative CHANCE Waiver will expire on September 30, 2014. At that time, any remaining waiver participants will be transitioned into appropriate supports and services, based on their needs.

CHANCE Waiver services are community- based services, which allow participants who are enrolled in the waiver, to remain in their homes or less-restrictive environments, while they receive the necessary supports in their respective communities. Eligible beneficiaries may receive CHANCE Waiver services from a variety of qualified Medicaid providers. Public and private agencies that have completed the required steps for becoming a qualified

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OVERVIEW (CONT'D.)

waiver service provider in the South Carolina Medicaid program, may deliver CHANCE Waiver services directly to eligible beneficiaries. In order to receive reimbursement from Medicaid, all CHANCE Waiver services rendered must be prior authorized by the SCDHHS CHANCE Waiver staff.

The purpose of this manual is to provide pertinent information to PRTF Alternative CHANCE Waiver providers, and to encourage successful participation in the South Carolina Medicaid program. This manual provides a comprehensive overview of the program, its standards, policies, and procedures for Medicaid compliance. All providers must meet the requirements in this policy manual; and must meet all applicable state and federal laws. The South Carolina Department of Health and Human Services (SCDHHS) is responsible for facilitating all updates and revisions to this manual, while also making it available to all providers.

SCDHHS encourages the use of "evidence-based" practices and "emerging best practices," which ensures thorough and appropriate screening, evaluation, diagnosis, and treatment planning. These practices foster effective and cost-efficient improvements in the delivery of mental health services to children and adults.

Note: Evidence-based practices are defined as preferential usage of mental and behavioral health interventions for which systematic empirical research has provided evidence of statistically significant effectiveness as treatments for specific problems.

Providers may utilize published lists of evidence-based practices, which may be produced by nationally recognized experts in the mental health field such as SAMSA and other professional associations.

PRTF Alternative CHANCE Waiver services are available to Medicaid eligible youth between the ages of 4-19 who meet PRTF level of care. Waiver services are not available to clients participating in a Managed Care Plan.

ADMINISTRATION

The PRTF Alternative CHANCE Waiver is operated and administered by SCDHHS, who provides guidance and oversight to participating agencies. This ensures compliance with waiver requirements and other rules and

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ADMINISTRATION (CONT'D.)

regulations under the provisions of the 1915(c) home- and community-based waiver. The SCDHHS contracts with several organizations that support waiver administration.

SCDHHS contracts with the Federation of Families of South Carolina (FFSC), a family advocacy organization, which provides waiver participants and their families with waiver advocacy and support, as well as other available alternatives. Intake functions for the waiver are conducted by FFSC, who receive referrals from a variety of sources throughout the state. After the referral intake process is completed, the organization contacts the families, and uses a screening tool to assess the prospective participant's need for waiver services. Families are required to submit documentation from a physician or clinician, which should indicate a Severe Emotional Disturbance (SED) diagnosis and/or a documented need for treatment services. If families are not able to access acceptable documentation from a physician or clinician, the FFSC will assist them in obtaining the required records. If it is determined that a prospective youth is not eligible for the waiver services, FFSC will refer the individual to other appropriate services that can meet their needs. In order to qualify for waiver services, the child must meet Medicaid financial eligibility, meet the age requirements for the waiver and meet the waiver level of care requirement. The FFSC sends all other applications for waiver services to SCDHHS, who is responsible for evaluating the applications and determining if the youth exhibits reasonable indications that they might need waiver services. If there is a reasonable indication of need and the child is not enrolled in Medicaid, Medicaid eligibility process will be initiated. The FFSC can assist families with applying for Medicaid and completing Medicaid eligibility documents, if needed. If the applicant is a Medicaid eligible beneficiary, the FFSC offers the family a list of qualified providers who can perform a level of care assessment. This will allow families to determine which provider to select for their participating child. The FFSC ensures that families have the opportunity to make informed decisions; however, the FFSC cannot recommend one provider over another.

South Carolina uses the Child and Adolescent Level of Care Utilization System (CALOCUS) assessment to determine if the participant meets the level of care for

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ADMINISTRATION (CONT'D.)

PRTF placement. If the level of care assessment indicates that the participant needs PRTF placement, the FFSC will discuss the service options with the family, which includes the PRTF placement and the CHANCE Waiver. If the family wants to receive services through the CHANCE Waiver, the family will complete a Freedom of Choice form documenting their choice/preference for waiver services. Families who have opted for waiver services can begin receiving services once they have signed the Rights and Responsibilities form, the Grievance and Appeals form, and the Informed Consent form. Families seeking waiver services must also select a case manager before they are eligible to begin receiving the services.

The PRTF Alternative CHANCE Waiver also contracts with the University of South Carolina's (USC) Center for Health Services and Policy Research, to collect and analyze data, evaluate data, and make recommendations, which ensures that the waiver meets program objectives. If the participant has signed the Informed Consent form, the individual will be asked to participate in a waiver study. This USC study assists SCDHHS in obtaining the data that drives the changes and improvements made to the waiver.

The Rights and Responsibilities and the Grievance and Appeals forms can be found in the Forms sections of this manual. The Informed Consent form is furnished by USC, and is accessible through the CHANCE Waiver Web site.

ASSURANCES

The PRTF Alternative CHANCE Waiver must guarantee that services are inclusive of the following assurances, when provided.

- Waiver participant health and safety
- Continual evaluation of eligibility, and need for waiver services
- Cost neutral – the cost of waiver services does not exceed that of PRTF placement costs
- Ongoing data collection, evaluation, and reporting of services provided to waiver participants
- Services are not duplicated
- Participants have freedom of choice

Waiver providers are responsible for ensuring compliance

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ASSURANCES (CONT'D.)

with the six waiver assurances during the service plan development process and throughout service delivery. SCDHHS monitors the waiver assurances, on a regular basis, to guarantee they are being met.

FREEDOM OF CHOICE FOR WAIVER PARTICIPANTS

Freedom of choice, for waiver participants, means that an individual can choose to receive home- and community-based services, rather than receiving services in a PRTF. Waiver participants can also choose to make informed decisions regarding staff and provider changes, when they are no longer satisfied with the supports and services they are receiving.

Eligible Medicaid beneficiaries who are enrolled in the waiver services, and who meet the level of care for the waiver, have the right to choose regarding the environment in which services are delivered, as well as a choice of who delivers the services. Eligible Medicaid beneficiaries, who will be enrolled in the CHANCE Waiver, are informed about South Carolina's service options. This allows them to make an informed decision about how they want their services delivered. **Waiver participants have the right to discontinue waiver services at any time, and for any reason.**

Freedom of choice allows participants and families the right to select home- and community-based services, or institutional care facilities, as well as the right to determine which provider renders services to the participant. Conversations about freedom of choice should occur annually. If a family determines that they would like to discharge from the waiver, or change providers, they should communicate their preference to their case manager, the FFSC, a trusted member of the services plan development team, or to SCDHHS.

The waiver screening process is conducted by family advocates from the FFSC. During this process, the family advocate should discuss freedom of choice with the participant and their family. This conversation should occur prior to them applying for services through the waiver. Upon entry into the waiver, each participant and their family must complete the Freedom of Choice form, which documents whether they want their services to be provided through the waiver or in a PRTF. Waiver participants have the right to choose any provider that is

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FREEDOM OF CHOICE FOR WAIVER PARTICIPANTS (CONT'D.)

willing and qualified to deliver waiver services. Participants and families can decide at any time to change providers. There are no restrictions on how often a family can change providers. However, families who choose to change providers will do so with the support of the FFSC. When a family requests a change in a waiver service provider, the family advocate will be available to discuss the repercussions of changing providers; for example, the impact that a provider change might have on the treatment that the participant receives. Families will never be discouraged from changing providers; however, efforts will be made to resolve any issues or concerns between the family and the current provider. In an event where issues and concerns cannot be resolved between the family and the current provider, the FFSC will support the family in choosing a new and qualified waiver services provider.

The Freedom of Choice form can be found in the Forms section of this manual.

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ENROLLMENT

Providers must comply with provider enrollment policies in order to continue as qualified waiver providers. The provider enrollment policy requires revalidation for Medicaid providers. In addition, all current providers must meet the provider enrollment standards at the time of revalidation. Each provider must:

- Identify their interest in being a CHANCE Waiver provider
- Meet the standard provider enrollment requirements
- Meet the supplemental CHANCE Waiver enrollment requirements
- Complete enrollment as a CHANCE Waiver provider

Organizations who successfully meet all enrollment criteria established by the Medicaid program, and who are designated as qualified providers, must determine which of the following CHANCE Waiver services, they can deliver. The following services, which are provided under the waiver, must be in accordance with this policy manual:

- Case Management Services
- Prevocational Services
- Respite Services
- Customized Goods and Services
- Intensive Family Services
- Medication Management and Wellness Education Services
- Peer Support Services
- Wraparound Paraprofessional Services
    - Behavioral Interventions
    - Independent Living Skills
    - Community Supports Services
    - Caregiver Services

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PROVIDER REQUIREMENTS

ENROLLMENT (CONT'D.)

Enrollment in the South Carolina Medicaid program does not provide a guarantee of referrals or a certain funding level. Failure to comply with all Medicaid policy requirements may result in termination of Medicaid enrollment.

As a condition of Medicaid program participation, providers must ensure that adequate and correct fiscal and medical records are kept. Such disclosures will indicate the extent of services rendered, and will also ensure that claims for funds are in accordance with all applicable laws, regulations, and policies.

All delivered services and claim submissions shall be in compliance with applicable federal and state laws and regulations, SCDHHS policies and procedures, and Medicaid provider manuals.

STAFF REQUIREMENTS

CHANCE Waiver providers must have documentation available, which verifies that all staff are properly qualified, screened, trained, and supervised. This includes volunteers, interns, and other individuals who are under the authority of providers who engage with CHANCE Waiver participants.

Providers must maintain current records of all staff credentials. The following list of required documents must be included in each personnel file, as appropriate. These records must be in place upon the start of employment, and prior to unsupervised contact with waiver participants.

- A resume or completed employment application
- A copy of the college diploma, high school diploma, GED, or official transcripts
- A copy of the professional license and/or certification – verified annually
- Letters or other documentation, which verifies previous employment, work experience, or volunteer work
- Motor Vehicle Records (MVR) for those members of the staff who are required to transport waiver patients – verified annually

Providers must identify a CEO or director responsible for the business operation of the entity. The provider must

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PROVIDER REQUIREMENTS

STAFF REQUIREMENTS (CONT'D.)

also identify a clinical director responsible for supervision of the CHANCE Waiver program. The clinical director must be a licensed and/or master's level clinical professional. An organization must include a clinical director and two other professional or paraprofessional staff persons that provide CHANCE Waiver services. **It is the provider's responsibility to ensure that their staff operates within the scope of practice, as required by South Carolina State law.**

Training

Providers are responsible for ensuring that all staff are appropriately trained. Providers are responsible for the development and provision of training to their staff, when alternative training is not available. **Training records must indicate the name of the training course, the instructor's name, the training agency, the date of training, and the signature sheet or signed attestation for those in attendance. (Signatures must be legible.)**

The following training must be administered to all staff who are responsible for delivering waiver services:

- **Pre-service Orientation:** Staff should not have unsupervised contact with waiver participants until this training is completed. Each staff member must sign an attestation indicating that they have been trained on the CHANCE Waiver policy within the first 30 days of their employment. **Staff members who have provided waiver services for more than one year, have until July 1, 2013 to receive training on the new waiver manual.**
- **Refresher Training:** This course covers the waiver and policy, and must be offered on a regular and/or as needed basis. **Signed attestations or training sign-in sheets must be kept as documentation of staff participation.**
- **Job Specific Training:** This course covers the roles and responsibilities of a staff person's position. Staff should not have unsupervised contact with waiver participants until this training is completed. **See the Services section of this manual for information regarding job specific training requirements.**

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Training (Cont'd.)

- **Other Required Training:** Changes in waiver policies or issues are often discovered during quality reviews, which will require additional training. Staff members are required to complete additional training in their respective role(s) if the changes or quality issues impact their specific job function(s). **Documentation should indicate that the information presented in the required trainings was shared with those staff members who provided waiver services, and who may be impacted.**
- **Abuse and Neglect Training:** This course focuses on mandated reporter requirements, critical incidents, and requirements for reporting abuse/neglect and critical incidents.

Note: These requirements do not apply to staff that provide Intensive Family Services, Medication Management, and Wellness education. Clinicians providing these services must meet requirements to maintain their licensure. Please see the Services section of this manual for more information about training requirements.

Screening

The following screenings for all unlicensed staff must be completed by the providers, as required. These records must be completed upon the start of employment, and prior to unsupervised contact with the waiver participants. In addition, the following records must be verified, annually. This includes staff, volunteers, interns, and other individuals who are under the authority of providers who engage with CHANCE Waiver participants.

- Criminal Record Check
  - Must be from an appropriate law enforcement agency
- Child Abuse Registry Verification
  - Results should not indicate any findings against an individual
- State and National Sex Offender Registries and the Child Abuse Registry Verification
  - Results should not indicate any findings or criminal charges against an individual

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DOCUMENTATION

Providers must have a file for each staff member, volunteer, intern, and other individuals who are under the authority of the provider, and who engage with CHANCE waiver participants. This file must include sufficient documentation of all training, screening, and credentialing requirements, as it pertains to the individual's job. Providers must comply with all other applicable state and federal requirements. Specific training requirements for each service type can be found in the section describing that service.

LIMITED ENGLISH PROFICIENCY

In accordance with the United States 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," the CHANCE Waiver requires the following:

The waiver intake process ensures that the language needs of participant's are assessed; and when appropriate, interpreter services will be provided. All waiver service providers must have a protocol system in place that allows access to services for persons with limited English proficiency. Designated staff, within the provider agencies, will be responsible for assuring compliance and access to services for persons with limited English proficiency.

The providers will be responsible for notifying SCDHHS of any discrimination complaints that are filed due to limited English proficiency. Providers are responsible for maintaining records, documenting any filed complaints, resolving complaints, and documenting complaint resolutions. These records will be reviewed by SCDHHS, as part of the overall quality assurance process.

The provider agency can request assistance from SCDHHS, who will assist them in identifying resources, when/if necessary. SCDHHS requires that each provider agency be in compliance with Title VI of the Civil Rights Act of 1964 and CFR title 45 part 80. Providers must establish a grievance procedure to assure that everyone is given a fair and timely review of all complaints that allege discrimination. Prior to enrollment approval, all providers must agree, in writing, to the "Assurance of Compliance" statement.

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EMERGENCY SAFETY INTERVENTION (ESI)

The Emergency Safety Intervention (ESI) policy applies to any community-based provider that has policies prohibiting the use of seclusion and restraint, but who may have an emergency situation requiring staff intervention. Providers must have a written policy and procedure for emergency situations and must ensure that direct care staff are prepared and trained in the event of an emergency. If the provider intends to use restraint and/or seclusion, the provider is responsible for adhering to the following requirements:

- Providers must ensure that all staff involved in the direct care of a beneficiary successfully complete a training program from a certified trainer in the use of restraints and seclusion. This must be accomplished prior to ordering or participating in any form of restraint.
- Training should be aimed at minimizing the use of such measures, as well as ensuring the beneficiary's safety. For more information on selecting training models, visit http://www.frcdsn.org/rest.html to view the *Project Rest Manual of Recommended Practice.*
- Providers must have a comprehensive written policy that governs the circumstances in which seclusion and restraint are being used. This policy must adhere to all state licensing laws and regulations (including all reporting requirements).

Failure to have these policies and staff trainings in place, at the time services are rendered, will result in termination from the Medicaid program, and possible recovery of payments.

CRITICAL INCIDENTS

All reports of crimes, abuse, neglect, or exploitation should be made to those state agencies who have statutory authority to receive reports, as well as those who have the authority to investigate allegations of suspected abuse, neglect, and exploitation, as described in South Carolina's Code of Laws Title 63-7.

All critical events or incidents that are discovered to have occurred under the purview of CHANCE Waiver providers/staff will be reported upon discovery to the appropriate entities. Such reports must be submitted to

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CRITICAL INCIDENTS (CONT'D.)

SCDHHS' CHANCE Waiver staff, within 24-hours, by the individual(s) who discover the incident(s). Incidents that rise to a level of a crime against Waiver participants will be immediately reported to law enforcement. Notification must be made to SCDHHS CHANCE Waiver staff within 24-hours. If the reported crime is alleged to have been committed by a staff, volunteer, intern, or other individual under the authority of the provider who comes into contact with CHANCE Waiver participants, that individual will not be permitted to have contact with waiver participants until/unless charges are dropped or resolved. This action is taken to ensure the protection of the participant receiving services. Those incidents that rise to the level of an allegation of abuse, neglect, or exploitation will be immediately reported to the South Carolina Department of Social Services (DSS), upon the discovery of the incident. SCDHHS CHANCE Waiver staff must also receive notification within 24-hours. If the allegation is made against a staff person, volunteer, or contracted employee, that individual will not be permitted to work or volunteer, while unsupervised, with waiver participants until SCDSS completes their investigation with findings of no substantiated abuse. All other critical incidents should be reported, as required, to SCDHHS and all other appropriate entities, within 48-hours, to ensure the safety of the waiver participants.

Law enforcement will respond to allegations of criminal acts, by investigating, when necessary, and will follow up with DSS, as needed. DSS will respond to allegations of participant neglect and abuse, implement safeguards, conduct investigations, and ensure the safety of participants, while in their respective homes. In addition, SCDSS will refer participants for services that can address any long term follow-up that may be needed to ensure the individual's safety.

The Service Plan Development (SPD) team should work with law enforcement and/or DSS case managers to determine if additional supports and services are needed to keep the participant's safe and free from abuse and in the least restrictive environments. SCDHHS will review critical events and incidents during annual Quality Reviews.

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REPORTING CHANGES

Changes affecting business operations must be reported, in writing, to the Medicaid Provider Service Center, as soon as possible. Certain changes may impact your status as a Medicaid provider. The following changes must be reported, on company letterhead, by the director/Chief Executive Officer(CEO):

- Physical addresses, e-mail addresses, or telephone numbers for the business office
- Change of location, or adding a location
- Director or CEO
- Clinical Director
- Staff licensure
- Business licenses
- Accreditation status
- Change in ownership
- South Carolina Department of Health and Environmental Control (SCDHEC) Residential Facility licensure
- DSS licensure
- New hires
- Other changes, which affects compliance with Medicaid requirements

Exceptional circumstances may require that a new Enrollment Application for the CHANCE Waiver be completed prior to approval.

Providers wishing to expand their Waiver services must obtain approval from the Division of Family Services program representative, prior to expansion.

Expansion is defined as adding a new population to be served, and adding an additional service.

CLOSURE OF A CHANCE WAIVER PROVIDER

In the event the provider is no longer operational and closes for business, the provider will adhere to all applicable federal and state laws, rules, and regulations, including but not limited to, the following requirements:

1. If the provider voluntarily terminates his or her agreement with Medicaid, a written notification

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CLOSURE OF A CHANCE WAIVER PROVIDER (CONT'D.)

must be received by SCDHHS and other appropriate agencies within 30-days of closing the facility. The notification shall include the location where the beneficiary and administrative records will be stored.

2. If the provider is terminated, involuntarily, by Medicaid, the provider is responsible for all beneficiary and administrative records, in the event of a post-payment review.

The owner(s) of the CHANCE Waiver business entity provider is responsible for retaining administrative and beneficiary records for five years.

QUALITY IMPROVEMENT

Any services that are provided by staff, who do not meet SCDHHS staff qualification requirements, are subject to recoupment.

CHANCE Waiver providers should self-monitor their adherence to waiver policies, rules, regulations, and laws, to ensure they are taking appropriate actions. SCDHHS will conduct annual administrative reviews, as needed, to ensure that providers are in compliance with Medicaid policies, state and federal laws, and requirements for the waiver. Other authoritative entities will conduct quality reviews of PRTF Alternative CHANCE Waiver providers, as needed.

All CHANCE Waiver providers must maintain and make available upon request, appropriate records and documentation of such requirements, qualifications, trainings, and investigations. Providers are given five business days to retrieve the records for those authoritative agencies who have requested the documents. All providers of CHANCE Waiver services shall maintain a file that ensures that each staff member meets the qualifications of the job that they perform. In addition, the service providers must submit a list of all staff (containing names, signatures, and initials) that administer waiver services.

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PARTICIPANT REQUIREMENTS

ELIGIBILITY FOR WAIVER SERVICES

As of October 1, 2012, enrollment for waiver participants is closed. Current waiver participants are eligible based on the following criteria, which also applies in the event that participant enrollment is reopened.

ELIGIBILITY

Medicaid-eligible beneficiaries may receive CHANCE Waiver services, if the individual meets the following criteria:

- Diagnosed with a SED
- Between ages four and 19
- Has an identifiable need for waiver services
- Meets the PRTF Level of Care eligibility requirements

Applicants who meet all eligibility requirements will be approved by the SCDHHS for enrollment and participation in CHANCE Waiver services.

In the event that enrollment is re-opened, the intake process will require applicants to provide documentation from their physician or clinician, regarding the applicant's diagnosis or need for PRTF-level supports and services. If this happens, the FFSC, a family advocacy organization, will assist applicants and their families with obtaining necessary documentation, if needed.

Grievances

The CHANCE Waiver utilizes a grievance/complaint system, which provides participants with an opportunity to file grievances or complaints when they are unsatisfied with their waiver services. The following is a list of possible grievances that may be addressed by CHANCE Waiver participants:

- Dissatisfaction with the way in which participant's and their families are treated
- Dissatisfaction with service delivery
- Dissatisfaction with service providers, or a specific staff member's performance
- Dissatisfaction with the course of treatment
- Dissatisfaction with the operating/administrative entity

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PARTICIPANT REQUIREMENTS

Grievances (Cont'd.)

Participants and/or their families are informed of their right to file grievances or complaints. Grievances may be filed when waiver participant's and/or their families feel that an action or inaction has violated their waiver rights. In these instances, participants and/or their families may believe that the violation(s) could not be adequately addressed through the SPD process. If participant's and/or their families have concerns, they should report their grievance(s) by contacting their FFSC advocate. Participants and/or their families must also submit a written statement, which addresses the specific nature of their grievance(s). In fact, grievances cannot be formally addressed until participants and/or their families submit their written statements, indicating their dissatisfaction. Once written statements are submitted, grievances are addressed through a local mediation process. An advocate from the FFSC is the mediator throughout this process. If grievances are resolved, SCDHHS will update the participant's records with written documentation. If the participant's and/or their families are not satisfied with mediation outcomes, they may submit a written appeal to SCDHHS' CHANCE waiver director. The family's advocate may assist them throughout this process. In addition, SCDHHS' waiver staff will investigate the grievance(s), as well as the issue(s) that were discussed in mediation sessions. SCDHHS must provide their written decision within 10-business days of receipt of the appeal submission. If the grievance(s) are resolved, SCDHHS will update the participant's records with written documentation. If the participant's and/or their families are not satisfied, and the grievance(s) afford the complainant fair hearing rights, then the participant's and/or their families may appeal the decision and utilize the fair hearing process. Grievances, which do not afford fair hearing rights, are completed with the decision of the SCDHHS waiver director.

The Grievance and Appeals Notice can be found in Forms section of this manual.

Appeals

A fair hearing is the process by which waiver participants and/or their families request that decisions be reconsidered (through an appeal), regarding the participant's eligibility for services.

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PARTICIPANT REQUIREMENTS

Appeals (Cont'd.)

Waiver participants have the right to request an appeal of any decision that adversely affects his or her eligibility status, receipt of services, and/or assistance.

Provider and operating/administering decisions, like: loss of eligibility, loss of access to services, and/or prevention of needed assistance, gives participants and/or their families fair hearing rights.

The FFSC is responsible for providing and explaining the appeals process to applicants and/or their families, prior to their entrance into the waiver system. The formal review process and adjudication of actions/determinations are facilitated 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.

Participants and/or their families who are interested in filing an appeal, must submit a written request for reconsideration of an adverse decision, to:

Division Director of Behavioral Health
South Carolina Department of Health and Human Services
PO Box 8206
Columbia, SC 29202-8206

Formal requests for reconsideration must be submitted, in writing, within 30-calendar days of receipt of written adverse decision notifications. The requests must indicate the basis of the complaint(s), previous efforts to resolve the complaint(s), as well as the desired resolutions. Requests for reconsiderations must be dated and signed by the participant or the participant's representative, who provides assistance during the request filing process. If necessary, the FFSC will assist the participant in filing their written request for reconsideration.

Participants, who want their waiver benefits/services to continue during the reconsideration/appeals process, must submit their requests for reconsideration within 10-calendar days of receipt of written adverse decision notifications. If the adverse action is upheld, participants may be required to repay waiver benefits received during the reconsideration/appeals process.

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Appeals (Cont'd.)

The division director of behavioral health, or his or her designee shall issue a written decision within 10-business days of receipt of the written reconsideration requests; and shall communicate this decision to the participant's and/or their designated representatives. If the division director/designee upholds the original adverse action/decisions, the specific reason(s) shall be identified in the written decision.

If the participant's and/or their designated representatives fully complete the above mentioned reconsideration process, and are dissatisfied with the results, the participant's and/or their designated representatives have the right to request an appeal. The purpose of an administrative appeal is to prove error, in fact, or law. Moving forward, the participant's and/or their designated representatives must submit written requests to the following address, no more than 30-calendar days after the date of the division director's written reconsideration decision.

Division of Appeals and Hearings
South Carolina Department of Health and Human Services
PO Box 8206
Columbia, SC 29202-8206

The participant's and/or their designated representatives must attach copies of the received SCDHHS written reconsideration notifications, which should include specific topics about the appeal. The participant's and/or their designated representatives must clearly indicate, with specificity, the issue(s) for appeal.

Unless the request is made to the above address within 30-calendar days of the date of SCDHHS' division director's written reconsideration decision, the decision will be final and binding. An appeals request is considered filed, at the above mentioned address, if postmarked by the thirtieth calendar day of the month, following the date of the division director's written reconsideration decision. The participant's and/or their designated representatives shall be advised by SCDHHS' Division of Appeals and Hearings, regarding the status of the appeals request.

The Grievance and Appeals Notice can be found in the Forms section of this manual.

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SERVICE PLAN DEVELOPMENT PROCESS

OVERVIEW

The Individualized Plan of Care (IPOC) is a waiver participant-focused document, which identifies how the assessed needs of each waiver participant are satisfied. An IPOC dictates how services are provided, who provides the services, and the waiver participant's individual health-related goals and projected outcomes. The Service Plan Development (SPD) team is responsible for developing all IPOCs.

SPD team meetings are facilitated by case managers, who are responsible for monitoring the waiver participant's IPOC. This process ensures that the IPOCs are reviewed and updated based on the waiver participant's needs. The SPD team is comprised of the waiver participant, his/her family, all waiver service providers, other behavioral health service providers, case managers, and any other relevant individuals who are chosen by the waiver participants and/or their families. The CHANCE Waiver encourages waiver participants and/or their families to take an active role in determining how waiver services are delivered, as well as determining who delivers those services.

Upon a participant's entry into a waiver, an initial level of care assessment serves as an IPOC. Once the waiver participants and/or their families select a case management provider, and the participants are enrolled in the waiver, services are ultimately rendered based on recommendations from the clinicians who perform the initial Child and Adolescent Level of Care Utilization System (CALOCUS) assessments. This happens prior to the development of an IPOC and budget. An IPOC must be developed within the first 30-days of a participant's entry into the waiver. This will present providers with an opportunity to continue billing for waiver services. However, IPOCs are developed through the SPD process; and all services are provided pursuant to the service plan.

In addition to developing an IPOC, the SPD team is also responsible for assessing a participant's IPOC accomplishments. The team must make recommendations

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SERVICE PLAN DEVELOPMENT PROCESS

OVERVIEW (CONT'D.)

for changes that may be beneficial to the participants and/or their families. As part of the SPD team, the participants and/or their families are also encouraged to take an active role in discussions about the individual's achievements.

The SPD team should be used to discuss the participant's treatment, progress, and goals for the future. Ultimately, the SPD team meetings should create an opportunity for team members to discuss how they can support the participants and/or their families. The team discussions should address necessary supports and thresholds for reducing a participant's need for intensive supports, while also improving the quality of life for them and their families.

REQUIREMENTS

The SPD team must review the waiver participant's IPOC every 90-days. All waiver service providers are expected to participate in SPD team processes by attending the 90-day review meetings. The SPD team may be required to meet more often, depending on the needs of the participants and/or their families. Case managers are responsible for planning and coordinating the 90-day SPD team meetings, and must also notify and invite all service providers and family advocates to the scheduled meetings. Participating providers, who are members of the SPD team, must be prepared to discuss the waiver participant's progress (or lack of progress), which may be exhibited during their treatments. Providers must also be prepared to review and discuss the waiver participant's current goals with the SPD team. This discussion will help the team determine if the participant's existing goals are still appropriate, given the individual's current status. The waiver participant's IPOC is developed based on the SPD team's review of the following:

- Level of care assessment recommendations, if applicable
- Previous IPOCs
- Discussions and recommendations for supports and services

It is important that all service providers participate in the development of the waiver participant's IPOC. Through this collaborative approach, each participating provider

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SERVICE PLAN DEVELOPMENT PROCESS

REQUIREMENTS (CONT'D.)

may contribute different levels of insight that represent their respective areas of expertise. This team approach will facilitate coordinated care and quality services, which appropriately addresses the needs of the waiver participants and/or their families.

Attendance

It is also important that all waiver service providers attend the 90-day SPD team meetings, to ensure that participants and/or their families receive coordinated care and adequate service provisions. Waiver service providers who are unable to physically attend SPD team meetings can utilize phone or video conferencing equipment, which will allow them to participate in offsite meetings. In the event that waiver service providers cannot attend or participate in 90-day SPD team meetings, the providers must collaborate with the participant's case manager and family to discuss the participant's progress (or lack of progress) in treatment. This collaborative effort will help the team determine if the participant's existing goals are still appropriate, given the individual's current status. In addition, the waiver providers and other members of the SPD team will have the opportunity to recommend future goals and supports.

Ideally, those waiver providers who are unable to attend SPD team meetings should maintain contact with the participant's case managers and family prior to the scheduled SPD team meetings. This will allow the case managers to share and discuss the provider's updates with the remaining members of the SPD team. Absent waiver service providers must retain documentation in the waiver participant's records, which indicates their participation in the SPD team process.

Case managers are required to maintain the following elements of the SPD team's participation records:

- Signatures for each team member, who physically attends the meetings
- A comprehensive list of each team member, who participated in meetings via telephone or video conferencing
- Documentation of collaboration with waiver service providers, who were unable to attend the team meetings

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Attendance (Cont'd.)

Note: Case managers and waiver service providers who are unable to attend meetings, should maintain regular contact to ensure that they remain abreast of a participant's status.

Desk Reviews

If the review meetings cannot occur within a 90-day period, case managers must contact the waiver participant's service providers, as well as the participant's family, to complete a desk review of the IPOCs. In addition, case managers must also document when a SPD team meeting is delayed, by clearly indicating the reasons for the delay on the IPOC desk review. Case managers must also provide explanations that justify why SPD team meetings could not occur. In addition, they must provide evidence of their failed attempts to schedule and hold meetings within the required 90-day time period. If a case manager reviews an IPOC, documents an acceptable reason for the delay, submits the documentation to SCDHHS, and receives a signed authorization from SCDHHS, the waiver providers can continue to bill for waiver services rendered, until the meeting can be held.

Note: Family scheduling conflicts are an example of acceptable reasons for delaying SPD team meetings. Waiver service providers will not be authorized to bill for services rendered until an IPOC is reviewed, as required, and as authorized by SCDHHS.

Desk review IPOCs must be signed by the designated case managers. Waiver participants and/or their families are encouraged to sign desk reviews; however, their signatures are not required for services to be authorized. Any changes made to an IPOC during a desk review must be communicated to the SPD team, as soon as possible. In addition, the changes must be discussed during future team meetings.

Revised IPOC documents must include the following:

- Indication that the revisions were discussed with the waiver participant's family, as well as the SPD team, prior to the suggested changes
- Documentation, which indicates a reason for need
- Documentation that appears in the progress summary (following the 90-day team meetings),

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Desk Reviews (Cont'd.)

which indicates that desk review of services were discussed by the team

However, the SPD team is required to meet when desk reviews are complete. This requirement is in keeping with the 90-day SPD team review.

Addendums

An IPOC may be amended at any time. If possible, such amendments should occur during SPD team meetings. Case managers may revise an IPOC without a need for a SPD team meeting, if the reasons for the changes are minor or urgent. If a team meeting is not held, case managers should use the same procedures that would be implemented if an IPOC could not be held within the 90-day time period. In these instances, an addendum to the IPOC must be submitted to SCDHHS. The addendum must include a budget, an authorization form, and an updated IPOC, which indicates the change. The addendum must be submitted to SCDHHS for authorization of the requested services.

Case managers must sign all addendums. Waiver participants and/or their families are also encouraged to sign the addendums; however, their signatures are not required for authorization of services. All emergency revisions made to an IPOC must be communicated to the SPD team, as soon as possible. Those changes should be discussed during future team meetings. Documentation must indicate the reasons for the revisions, and must also indicate that the revisions were discussed with the waiver participants and/or their families. The progress summary, following the 90-day team meetings, must include documentation that indicates that the changes of services were discussed by the team.

Essential Elements of the IPOC

An IPOC is a packet of documents that providers are required to have in order to be eligible for reimbursement for waiver services rendered. All documents in an IPOC packet must include appropriately identifiable information on each page of the plan. For example: full names, Medicaid ID numbers, dates of birth, and dates of IPOCs. The documents in an IPOC packet must have the following elements:

- Individualized Plan of Care (the treatment plan)
    - Basic background information on the waiver participant, which indicates their skills,

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Essential Elements of the IPOC (Cont'd.)

strengths, long term goals and justification of their need for services

- Type of services
- Service providers and contact persons
- Frequency of the services
- Participant's goals
- Specific actions that providers should take to address the participant's goals
  - Target dates for accomplishing the intended goals
    Note: The service provision is based on the goals identified in an IPOC.
- Case manager's signature, professional title and signature date
- The participants and/or their families signature and signature date

- Budgets,
  - Indicates expected waiver service expenditures
  - Start and end dates for delivered services
  - Cost neutral (cost of services must be less than PRTF placements)
  - Case manager's signature, professional title and signature date
  - The participants and/or their families signature and signature date
- Authorization documents - completed and signed by the case manager and SCDHHS' waiver staff
- Crisis plan
- 90-day summaries – summary of the SPD meetings
- SPD team participation records

While the waiver participant receives case management through the waiver, an IPOC should incorporate all of the supports and services, which allows the participant to remain in the least restrictive environment. This includes state plan services, school-funded supports, church-funded supports, community supports, and natural supports.

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Essential Elements of the IPOC (Cont'd.)

The case manager is responsible for the completion of other required paperwork, following the 90-day meetings. The case manager is also responsible for writing the IPOC, based on the level of care recommendations, as well as SPD team feedback.

Plan Dates

An IPOC remains effective and authorized for a 90-day time period. The review must occur prior to the expiration of the previous plan. The following provides an example of how the 90-day time period occurs.

- If an IPOC is dated June 1, 2012 to September 1, 2012, the next plan must be reviewed on or before the expiration. This timeframe will allow the new plan to become effective on September 1, 2012. This also ensures that there are no interruptions in service authorization.
- If an IPOC ends on September 1, 2012, and the next authorized IPOC is dated September 10, 2012, services will not be authorized from September 2-9, 2012.
- If it is discovered that a provider billed for services during the timeframe in which an IPOC was not in place, those paid claims will be subject to recoupment. The 90-day review of the plan may occur prior to the plan expiration date. If the expiration of the IPOC occurs on a weekend, holiday, or could not be held due to scheduling reasons, the review date may be different from the start date of the new plan. In this instance, the changes to an IPOC should become effective on the start date of the plan, rather than on the date of the review. The following provides additional examples of how the dates can impact the 90-day plan.
- If the expiration date of an IPOC is December 1, 2012, but for scheduling purposes, the SPD team meeting is held on November 28, 2012, the dates of the new IPOC should be December 1, 2012 through March 1, 2013. This is possible because the changes discussed in this meeting will not become effective until December 1, 2012.

If changes to current services are needed within the 90-day time period, an addendum should be submitted. The date of

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SERVICE PLAN DEVELOPMENT PROCESS

Plan Dates (Cont'd.)

the addendum should be the date of the change through the expiration of the current IPOC. The following provides an example of how to date an addendum.

- If a current IPOC is dated September 1, 2012 through December 1, 2012, and changes in services are identified on November 20, 2012, the date of the addendum should be November 20, through December 1, 2012. This would be an addition to the original budget.

Note: Review dates and start dates are not necessarily the same; however, a start date cannot be prior to the review date.

Abbreviations and Symbols

Abbreviations may be used in the IPOC or the clinical service note. Service providers shall maintain a list of abbreviations and symbols used in clinical documentation, which leaves no doubt as to the meaning of the documentation. An abbreviation key must be maintained to support the use of abbreviations and symbols in entries. Providers must furnish the list and abbreviation key upon request of SCDHHS and/or its designee.

Legibility

All clinical documentation must be typed or legibly handwritten, using black or blue ink, only, and filed in chronological order. All clinical records must be current, consistently organized, and meet documentation requirements. Records must be arranged in a logical order so they can be easily and clearly reviewed, copied, and audited. Original signatures and credentials (*e.g.*, registered nurse) or functional titles (*e.g.*, SAP, MHP) of the person rendering the service must be present in all clinical documentation. Photocopied signatures, stamped signatures, or signatures of anyone other than the person rendering the service or co-signature, when required, are not acceptable. (See Section 1 of this manual for the use of electronic signatures and/or exceptions.)

Error Correction

Clinical records are legal documents. Staff should be extremely cautious in making alterations to the records. In the event that errors are made, adhere to the following guidelines:

- Draw one line through the error, and write "error," "ER," "mistaken entry," or "ME" to the side of the error in parenthesis. Enter the correction, sign or initial, and date the revision.

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Error Correction (Cont'd.)

- Errors cannot be totally marked through. The information in error must remain legible.
- No correction fluid may be used. If an explanation is necessary to explain the corrections, they must be entered in a separate CSN.

Late Entries

Late entries (entries to provide additional documentation to supplement entries previously written) may be necessary at times, to handle omissions in documentation. Late entries should rarely be used, and then only to correct a genuine error of omission or to add new information that was not discovered until a later time. When late entries are made, adhere to the following guidelines:

- Identify the new entry as a "late entry"
- Enter the current date and time
- Identify or refer to the date and incident for which the late entry is written
- If the late entry is used to document an omission, validate the source of additional information, as much as possible
- When using late entries, document as soon as possible

Record Retention

Clinical records shall be retained for a period of five years. If any litigation, claim, or other actions involving the records have been initiated prior to the expiration of the five-year period, the records shall be retained until completion of the action and resolution of all issues that arise from it, or until the end of the five-year period, whichever is later. In the event of an entity's closure, providers must notify SCDHHS regarding medical records. Clinical records must be arranged in a logical order to facilitate the review, copy, and audit of the clinical information and course of treatment. Clinical records will be kept confidential, in accordance with the Health Insurance Portability and Accountability Act (HIPAA) regulations, and safeguarded, as outlined in Section 1 of this manual.

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AUTHORIZATIONS

Case managers are responsible for submitting all required IPOC documents to SCDHHS, so that waiver services can be authorized. Submissions must be timely, which ensures that services do not lapse for waiver participants. The entire IPOC must be submitted, along with any other required documentation that supports a need for services. If SCDHHS identifies any errors during the review process, they will request that the necessary corrections be made. This will delay the authorization of waiver services. In addition, waiver services will not be authorized if an IPOC has errors or is missing essential elements. To ensure that there are no delays, please review all IPOCs prior to submitting the documents to SCDHHS. An IPOC must be submitted to SCDHHS immediately following IPOC meetings.

SCDHHS will review the IPOCs, and will authorize waiver services, as appropriate. They will also review and authorize plans based on the following criteria:

- The waiver participants and/or their families individual needs
- Review of the plans, which evaluates waiver assurances (freedom of choice, health and safety, cost neutrality, family and provider participation in plan development, continued eligibility, and need for services)
- Review of the plans to ensure that essential elements of an IPOC are included
- Waiver services are only authorized for the 90-day time period indicated on the budget

Note: Waiver services are only authorized when providers receive signed authorization from SCDHHS' waiver department.

DISTRIBUTION

Once authorized by SCDHHS, case managers are responsible for ensuring that all service providers receive full copies of IPOCs, by including all attachments, as well as the necessary authorizations for waiver services. Each member of the SPD team is responsible for reviewing an IPOC once they receive the documents. This ensures that the team's decisions are accurately represented in an IPOC. Any discrepancies found in an IPOC should be identified, and brought to the attention of the designated case

SECTION 2 POLICIES AND PROCEDURES

SERVICE PLAN DEVELOPMENT PROCESS

DISTRIBUTION (CONT'D.)

manager. This should occur as soon as possible, so that all concerns can be resolved appropriately. Waiver service provisions are based on the waiver participant's goals, which are indicated in the IPOCs. As a result, it is required that each waiver service provider obtains a copy of the IPOC, and retains copies for their records.

Copies of an IPOC and all supplemental attachments must be sent to waiver participants and/or their families immediately following SCDHHS' authorization of services.

UTILIZATION

SCDHHS requires prior authorization for all PRTF Alternative CHANCE Waiver services that are provided. CHANCE Waiver providers will ensure that only authorized services are provided and submitted to SCDHHS for reimbursement. CHANCE Waiver providers will also ensure that all services are provided in accordance to Medicaid policies, waiver service policies, as well as state and federal laws.

SCDHHS will conduct periodic utilization reviews, whereby reimbursements received in excess of the authorized amounts and durations will be subject to recoupment.

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SERVICE PLAN DEVELOPMENT PROCESS

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SECTION 2 POLICIES AND PROCEDURES

WAIVER SERVICES

CHANCE WAIVER CASE MANAGEMENT

Service Description

CHANCE Waiver Case Management assists individuals in gaining access to needed waiver services, State Plan services, and services funded through other sources. Case Management for the CHANCE Waiver can encompass the coordination of services related to the entire person. This may include the need for behavioral, medical, social, educational, and other services, regardless of the funding source.

CHANCE Waiver case managers administer ongoing monitoring and coordination of service provisions. They are also responsible for coordination of the 90-day SPD team reviews, completion of the IPOCs—based on feedback from the meetings, and completion of other required documentation following the review.

CHANCE Waiver providers who render Case Management services cannot provide other waiver services to the same participant while he or she is assigned to their workload. Case managers may provide other waiver services to participants who are not included in their respective caseloads.

Transitional Case Management Services

Transitional Case Management provides services to individuals placed in a PRTF prior to their transition to the CHANCE Waiver. Services are administered by case managers and can be provided up to 180-consecutive days, prior to admission into the waiver. Transitional Case Management services are available to participants, in institutional settings, who will transition into the community in advance of their placement into the CHANCE waiver program. Providers cannot bill for Transitional Case Management services until the participant has been discharged from the PRTF and placed in the waiver.

Eligibility

Individuals enrolled in the PRTF Alternative CHANCE Waiver receive Case Management services to coordinate their care. Service needs are assessed, discussed, and

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WAIVER SERVICES

Eligibility (Cont'd.)

determined by the SPD team. This team must include the waiver participants and their families. The determination of eligibility for continued CHANCE Waiver services must be documented in the participant's service record. The annual Level of Care eligibility determination for waiver services includes the CALOCUS assessment, Child Behavioral Checklist (CBCL), and the behavioral health assessment. If available, a letter from SCDHHS, which indicates that a beneficiary is enrolled in the PRTF Alternative CHANCE Waiver, should also be included in the service record. Case Management services must be appropriately identified as a service in the budget, as well as in the IPOC. Prior authorizations for Case Management services must be signed by CHANCE Waiver staff, and should be included in the participant's service record.

Billing Requirements

A qualified CHANCE Waiver Case Management provider will be reimbursed for services based on an SCDHHS-approved IPOC; however, providers must document the need for Case Management. The IPOC must be updated within 90-days. The IPOC must document the following: type of Case Management service, provider agency, date service began, frequency, target date or duration, and goals/objectives for the provision of case management.

Billable services include face-to-face and telephonic interactions with the participant and/or a family member. A billable Case Management interaction must address the waiver participant's goals, which are specified in the IPOC.

There must be documentation of at least one face-to-face contact, and at least one telephonic contact, which will allow providers to bill for CHANCE Waiver Case Management services. During face-to-face contact, case managers must see the participant. Case Management services are billed in 15-minute units. Other required activities are built into the case management rate, and are not billable activities.

CHANCE Waiver Case Management must be pre-authorized by CHANCE Waiver staff before a provider can bill for services that they rendered. SCDHHS will pursue recoupment of funds if they determine that a provider has billed for services, inappropriately, or if those services were not pre-authorized by its CHANCE Waiver staff. In fact, CHANCE Waiver staff will authorize units based on the needs of the individual.

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WAIVER SERVICES

Documentation

In order for providers to be reimbursed by Medicaid for CHANCE Waiver Case Management services, Case Management must be listed on the current budget, SCDHHS authorization, and IPOC.

Providers must be able to provide documentation, in the form of a service note, which includes the following information:

- The service is identified as Case Management
- Provider of the service
- Name and title of the person rendering the service
- Name, date of birth, and Medicaid number of the waiver participant
- Date of service
- Goal(s) addressed
- Staff action
- Waiver participant's response to staff's action
- Duration of services provided
- Signature of person rendering the service
- Date the note was written

Some allowable activities for CHANCE Waiver Case Management professionals, are:

- Meeting with the participant and their family to discuss needs
- Discussing the waiver participant's progress with the SPD team, in the presence of the participant and his or her family
- Telephonic contact with the waiver participant and/or their family, regarding their respective Case Management goals
- Discussing freedom of choice with the participant and their family, so that they can make informed decisions about who will provide services
- Reviewing the IPOC with the participant and parent/guardian, to ensure their understanding of the treatment plan

SECTION 2 POLICIES AND PROCEDURES

WAIVER SERVICES

Documentation (Cont'd.)

All Case Management activities must be documented; however, some of the activities are not billable. Nevertheless, all Case Management activities are an important part of coordinated care, and must be documented.

The following activities are not billable services under the CHANCE Waiver:

- Writing the IPOC
- Holding a POC meeting without the presence of a waiver participant and/or a member of their family
- Quality assurance reviews
- Talking with other service providers regarding progress (without the presence of the waiver participant and/or their parent or guardian)
- Facilitating a relationship with another provider to secure services for a waiver participant (without the presence of the waiver participant and/or their parent or guardian)
- Submitting the IPOC documentation to SCDHHS, for authorization of services
- Mailing the IPOC to waiver participants and the service providers

Staff Requirements

CHANCE Waiver case managers must be employed by a public or private qualified CHANCE Waiver provider, and must also have one of the following qualifications:

- A master's degree in social work, psychology, counseling, special education, or a degree in a closely related field
- A baccalaureate degree in social work, psychology, counseling, special education, or a degree in a closely related field, with at least one year of experience performing clinical or case work activities
- A baccalaureate degree in an unrelated field of study, and at least three years of experience performing clinical or case work activities
- A registered nurse, licensed to practice in South Carolina, with at least three years of experience performing clinical or case work activities

SECTION 2 POLICIES AND PROCEDURES

WAIVER SERVICES

Staff Requirements (Cont'd.)

Providers must ensure that appropriate background checks and screenings are completed for all staff, volunteers, interns, and other individuals who are under the authority of the provider, and who have direct contact with CHANCE Waiver participants.

Staff Training

Case managers must complete all applicable training requirements listed in the "Provider Requirements" section of this document. Providers are responsible for retaining training documentation in each case manager's personnel file. Records should be available for all staff that provided Case Management during the past three years.

New case managers must complete a CHANCE Waiver Case Management training prior to having unsupervised contact with waiver participants. Providers are responsible for ensuring that case managers are appropriately trained on CHANCE Waiver and South Carolina Medicaid policies and procedures.

SCDHHS has published an online Case Management training that outlines the essential information case managers need to know. It is the responsibility of the providers to deliver the online training to their staff, as appropriate. Any major deviation from the SCDHHS-outlined trainings must be made available during administrative reviews to ensure that the essential elements of the trainings are presented to case managers during the training sessions. All case managers are required to sign a case management training attestation, indicating that they received the training and understand the contents of the information presented. Training attestation statements for new case managers must be submitted to CHANCE Waiver staff, at the following address:

South Carolina Department of Health and Human Services
PO Box 8206
Columbia, SC 29202-8206

CHANCE Waiver case managers are required to take annual refresher trainings, as well. Providers are responsible for administering the refresher trainings, when appropriate. They are responsible for retaining documentation of annual trainings, for all waiver case managers.

SECTION 2 POLICIES AND PROCEDURES

WAIVER SERVICES

Staff Training (Cont'd.)

SCDHHS Case Management training information can be found at the following Web site:

https://msp.scdhhs.gov/chance/content/training

PREVOCATIONAL SERVICES

Service Description

Prevocational Services prepare a CHANCE Waiver participant for paid or unpaid employment. Prevocational activities are based on building skills in areas that will help the participant secure employment. Prevocational activities include, but are not limited to:

- Resume writing
- Personal care awareness (hygiene and appropriate dress for the work place)
- Interview skills
- Appropriate work behavior
- Customer service
- Budgeting and balancing a checkbook
- Compliance with rules
- Attendance
- Task completion
- Problem solving
- Improving attention span and safety awareness

Prevocational Services are not job-task oriented activities, but instead, are aimed at skill building to better prepare participants for entrance into the working world. Services may be furnished at the provider's facility, in a community-type setting, or at the waiver participant's home.

The appropriate supervision of the participant, by CHANCE Waiver staff, is required while rendering services. Supervisors must be available 24-hours per day/7-days per week, to assist with emergencies. In addition, supervisors must be available to discuss treatment progress, and to provide guidance and instruction, when needed. Supervisors must provide regular guidance, oversight, and monitoring for prevocational staff and the

SECTION 2 POLICIES AND PROCEDURES

WAIVER SERVICES

Service Description (Cont'd.)

delivery of services. Transportation between the participant's residence and the prevocational services site is provided as a component of the service, and is included in the rate paid to providers.

Documentation must be retained in the participant's file as evidence that the service is not available through a program funded under section 110 of the Rehabilitation Act of 1973 of the IDEA (20 U.S.C. 1401 et.seq.).

Eligibility

Individuals enrolled in the CHANCE Waiver program are eligible for Prevocational Services, as needed. Service needs will be assessed, discussed, and determined by the SPD team. This team must include the waiver participants and/or their families. The service record must document that the participant continues to meet eligibility requirements for this service. Prevocational Services must be appropriately identified as a service, in the budget, as well as in the IPOC. The service must be a pre-authorized by SCDHHS' CHANCE Waiver staff.

Billing Requirements

In order for a qualified CHANCE Waiver provider to receive reimbursement from Medicaid, the provider must possess an SCDHHS-approved IPOC that authorizes Prevocational Services for a waiver participant. The IPOC must be written within 90-days and must document the following: Prevocational Services listed as a service, provider agency, date service began, frequency, target date or duration, and goals and/or objectives listed in the IPOC.

Billable Prevocational Services are face-to-face skill-building interactions with the waiver participant. A billable interaction must address the waiver participant's goals specified in the IPOC. Services are billed in 30-minute units.

Other required Prevocational activities are built into the prevocational rate, and are not billable activities. These activities may include attending the SPD team meetings; reviewing the IPOC to ensure the treatment is consistent with the IPOC goals; communicating progress with the participant's case manager and family; documenting services; and quality assurance self-monitoring.

Prevocational Services must be pre-authorized by CHANCE Waiver staff before a provider is permitted to

SECTION 2 POLICIES AND PROCEDURES

WAIVER SERVICES

Billing Requirements (Cont'd.)

bill for services. SCDHHS will pursue recoupment if they determine that a provider has billed for services inappropriately, or if those services were not pre-authorized by CHANCE Waiver staff. In fact, CHANCE Waiver staff will authorize units based on the needs of the individual.

Documentation

In order for providers to be reimbursed by Medicaid for Prevocational Services, Prevocational must be listed on the current budget, SCDHHS authorization, and IPOC.

Providers must be able to submit documentation in the form of a service note that includes the following information:

- The service is identified as Prevocational
- Provider of the service
- Name and title of the person rendering the service
- Name of waiver participant, date of birth, and Medicaid ID number
- Date the service was delivered
- Goal(s) addressed
- Staff action
- Waiver participant's response to staff's action
- Duration of services provided
- Signature of person rendering the service
- Date the note was written

Allowable activities for Prevocational Services professionals include, but are not limited to, mock job interviews, budgeting and banking, resume writing, volunteering, structured lessons, discussions, and other activities that support prevocational skill-building.

All activities must be documented in the service note. Some activities are not billable activities, but are an important part of coordinated care, and must be documented in the service record, as well.

The following activities are important functions, but are not billable services under the CHANCE Waiver:

- Attendance at a plan of care meeting
- Quality assurance reviews

SECTION 2 POLICIES AND PROCEDURES

WAIVER SERVICES

Documentation (Cont'd.)

- Communicating with other service providers, regarding progress
- Prevocational Other activities that are not face-to-face
- Service activities that contribute to more positive outcomes for the waiver participant

Staff Requirements

Prevocational staff must have at least a high school diploma, or equivalent. Supervisors must be master's level clinicians or above.

Providers must ensure the appropriate background checks and screenings are completed for all staff, volunteers, interns, and other individuals under the authority of the provider who interact with CHANCE Waiver participants.

Staff Training

Providers rendering Prevocational Services must ensure that all staff and supervisors successfully complete a training program. The training program must include Prevocational concepts and skill-building activities. Annual training is required for all employees, in accordance with CHANCE Waiver and South Carolina Medicaid policy.

It is the responsibility of the providers to deliver Prevocational training to their staff prior to unsupervised contact with a waiver participant. Providers can deliver training as they see fit, based on the program structure and demands. Providers are responsible for retaining documentation of the training curriculum and training records for all Prevocational staff and supervisors.

Providers must ensure all supervisors maintain their clinical licenses while overseeing or rendering Prevocational Services.

RESPITE SERVICES

Service Description

The intent of this service is to provide short-term supports to relieve the primary caregiver from the stress, fatigue, and discord associated with caring for a participant with severe emotional and/or behavioral disturbance. The primary beneficiary of this service is the family unit. The goal is to promote the emotional health and wellbeing of the family.

SECTION 2 POLICIES AND PROCEDURES

WAIVER SERVICES

Service Description (Cont'd.)

Respite Services offer temporary relief from caregiving for many families. The opportunity to break away from the participant increases the likelihood of keeping the participant in the least restrictive environment, ideally the family home. Respite Services build resiliency in the family by providing primary caregivers and other affected family members with the opportunity to focus on their own needs, and to refresh themselves emotionally and physically.

Respite providers are responsible for offering a safe and supportive environment for participants. Activities should engage the participant in healthy, safe, and age-appropriate activities.

Eligibility

Individuals enrolled in the CHANCE Waiver can receive Respite Services, as needed. Service needs are assessed, discussed, and determined by the SPD team. This team must include the waiver participants and their families. The demonstration of continued waiver eligibility must be documented in the participant's file. Respite Services must be appropriately identified as a service in the budget, the SCDHHS authorization, and in the IPOC.

Billing Requirements

A qualified CHANCE Waiver provider must have an IPOC authorizing Respite Services to be eligible for Medicaid reimbursement. The IPOC must be written within the past 90-days, and must document the following: Respite Services listed as a service, provider agency, date service began, frequency, target date or duration, and goal(s) listed on the IPOC.

Respite Services are billed on a per diem basis in 15-minute units, or at a capped daily rate. Services are rendered as In-Home Respite (waiver participant's home) or as Residential Respite (foster home).

Providers cannot bill for an In-Home Respite interaction as an overnight service. However, an overnight Respite Service can be provided in a Residential Respite setting. The capped daily rate for Residential Respite can be used when waiver participants are staying for longer periods (more than seven hours) or overnight at a foster home. Federal Financial Participation (FFP) cannot be claimed for room and board for Residential Respite.

SECTION 2 POLICIES AND PROCEDURES

WAIVER SERVICES

Billing Requirements (Cont'd.)

Respite must be pre-authorized by CHANCE Waiver staff before a provider can bill for services rendered to the participant. SCDHHS will pursue recoupment of funds if they determine that a provider has billed for services inappropriately, or if those services were not pre-authorized by CHANCE Waiver staff.

Respite must be appropriately identified as a service in the budget and in the IPOC. Prior authorizations for Respite Services must be signed by SCDHHS CHANCE staff, and must be in the participant's service record. CHANCE Waiver staff will authorize units based on the needs of the individual.

Documentation

In order for providers to be reimbursed by Medicaid for Respite services, Respite must be listed in the current budget, SCDHHS authorization, and in the IPOC.

Providers must be able to provide documentation in the form of a service log, which includes the following information:

- The service identified as Respite
- Provider of the service
- Name and title of the person rendering the service
- Name of waiver participant, date of birth, and Medicaid ID number
- Date the service was delivered
- Duration of services provided
- Signature of person rendering the service

The following activities are required functions of a Respite provider, but are not billable activities under the CHANCE Waiver:

- Attending a POC meeting
- Quality assurance reviews
- Communicating with the case manager regarding progress
- Other activities related to the SPD process or administrative activities, regarding the waiver participant's Respite Services

SECTION 2 POLICIES AND PROCEDURES

WAIVER SERVICES

Staff Requirements

In-Home Respite Services

In-Home Respite Services are provided in the participant's home. In-Home Respite staff must be employed by a qualified CHANCE Waiver Respite provider, and must successfully complete all required training.

Staff must meet the following requirements:

- Be at least 21-years of age or older
- Have knowledge of the needs of children and capable of meeting the needs of children in the waiver program
- Be capable of handling an emergency situation
- Have a minimum of 14-hours per year of appropriate respite care training and expected standards of care
- Have a minimum of three written letters of reference

  Note: Reference letters must be obtained prior to providing services to the participant. References must know the applicants for at least three years prior to the application; and unless specifically requested, they must not be related to the applicants.

Supervisor Qualifications

Supervisors of In-Home Respite staff must meet **one** of the following qualifications:

- A master's degree in social work, psychology, counseling, special education, or in a closely related field
- A baccalaureate degree in social work, psychology, counseling, special education, or in a closely related field and have at least one year of experience performing clinical or case work activities
- A baccalaureate degree in an unrelated field of study and at least three years of experience performing clinical or case work activities
- A registered nurse, licensed to practice in South Carolina, and have at least three years of

SECTION 2 POLICIES AND PROCEDURES

WAIVER SERVICES

Supervisor Qualifications (Cont'd.)

experience performing clinical or case work activities

Residential Respite Services

Residential Respite Services are provided to participants in foster home settings. Providers must have a current Department of Social Services (DSS) license as a foster care placement institution. In addition, foster homes must be individually licensed by DSS as a "foster care home." Foster homes must meet all DSS requirements and standards for licensure.

Providers must be in good standing in accordance with South Carolina Medicaid regulations. The foster home parents and agency staff must be licensed and credentialed in accordance with South Carolina Medicaid policy.

Staff Training

Supervisors must ensure that all employees participate in required training. Providers are responsible for training their Respite staff as they see fit based on the participant and structure of the Respite program. Providers must maintain records of the training curriculum and staff sign-in sheets or signed attestations. The records must show proof that the required training hours were completed annually.

Residential Respite providers must maintain DSS licensure standards and training requirements as stated above. Providers are responsible for retaining training records for staff and providing Respite services to waiver participants.

All agencies that rendering In-Home and/or Residential Respite must ensure that all employees participate in required annual training per CHANCE Waiver and South Carolina Medicaid policy.

CUSTOMIZED GOODS AND SERVICES

Service Description

The CHANCE Waiver program provides funding for services and goods that enhance the participant's success for treatment outcomes. The funds are used to purchase a variety of one-time or occasional goods and/or services that would otherwise present barriers to participation in the waiver program.

SECTION 2 POLICIES AND PROCEDURES

WAIVER SERVICES

Service Description (Cont'd.)

The SPD team will identify the need for goods and services. The justification for goods and services must be documented in the IPOC. The documentation must clearly identify specific goods or services for purchase, and must also identify the IPOC goals that each purchase will address. Written justification for goods and services must be submitted and must indicate the following:

- The specific item or service for purchase
- The specific vendor supplying the item or service for purchase
- Justification of the need for services related to the participant's goals, as stated in the IPOC.

The budget must identify the funds to be allocated for the purchases. All quotes and/or receipts for the cost of the items or services must be submitted to SCDHHS. Documentation for goods and services, along with the IPOC, must be submitted to SCDHHS by the case manager.

The final approval for requested funds for the purchase of goods and services are included as part of the overall POC and budget approval process, which is conducted by the CHANCE Waiver staff. In fact, the CHANCE Waiver staff will review requests and authorize purchases in accordance with the needs and desired treatment outcomes stated in the IPOC.

The SPD team is required to meet and review to determine a participant's continued need for services, at least every 90-days from the date of the initial team meeting. The review should address issues, such as: whether or not purchases were effective in meeting goals; if purchases were delivered in a timely manner, and if purchases were utilized for the intended purpose.

Goods and services purchased under this coverage must not circumvent other restrictions of waiver services, including the prohibition against claiming for the costs of room and board.

SECTION 2 POLICIES AND PROCEDURES

WAIVER SERVICES

Case Manager Responsibilities

The case manager must provide support and assistance to the participant and/or their family in determining where to purchase an item or a service. The case manager will make direct payments to the specified vendor for the goods and services. It is the case manager's responsibility to ensure that purchases are appropriately utilized by the participant. The case manager must record all goods and services purchased and retain all receipts and invoices. The purchase of goods and services are subject to review, at any time. This includes potential reviews during annual Quality Improvement reviews of Case Management. The waiver participant's case manager, for whom the goods and services are being purchased, is not eligible to serve as the vendor from which goods or services are purchased.

Eligibility

Individuals enrolled in the CHANCE Waiver can receive funds for Customized Goods and Services as needed. Service needs are assessed, discussed, and determined by the SPD team. This team must include the waiver participant and their family. The demonstration of continued waiver eligibility must be documented in the participant's service record. Customized Goods and Services must be appropriately identified as a service in the budget and in the IPOC. All Customized Goods and Services must be pre-authorized by CHANCE Waiver staff.

Billing Requirements

In order for providers to receive funding for Customized Goods and Service, an SCDHHS-approved IPOC must specify the goods and services authorized for the participant and/or their family. Providers must have documented the need for goods and services in the IPOC. The IPOC must be written within the past 90-days, and must document the following: Customized Goods and Services listed as a service, provider agency, date service began, frequency, target date or duration, and treatment goal(s) related to this item or service. The case manager must submit a budget, POC, and an authorization request for goods and services along with the following:

- A 90-day summary indicating that the SPD team discussed a need for a specific items for the participant and/or their family

SECTION 2 POLICIES AND PROCEDURES

WAIVER SERVICES

Billing Requirements (Cont'd.)

- A written justification explaining why the purchase of a specific item or service positively impacts the treatment outcomes for the participant
- A quote, brochure, or receipt from a specific vendor, which indicates the exact cost of the purchase

Receipts for all goods and service purchases must be retained with the case management records.

Requests for Customized Goods and Services must be for specific items. Some examples of covered goods and services are school supplies, furniture, a new winter coat, a week at the YMCA's summer camp, a 3-month gym membership, or piano lessons. Goods and services are not reimbursable unless all required documentation is submitted to SCDHHS for authorization and the provider has received an approved authorization request.

There is a lifetime cap per waiver participant for goods and services. Once a participant has spent this amount, he or she will no longer be eligible to receive reimbursement through the CHANCE Waiver. CHANCE Waiver staff will authorize units based on the needs of the individual.

Customized Goods and Services must be pre-authorized by CHANCE Waiver staff in order for a provider to receive reimbursement from Medicaid. SCDHHS will pursue the recoupment of funds if they determine a provider has billed for goods or services inappropriately, or if those goods or services were not pre-authorized by CHANCE Waiver staff. CHANCE Waiver staff will authorize goods and services based on the needs of the individual.

Documentation

The purchases must be documented to ensure the waiver participants receive the goods and services specified in the IPOC.

The following documentation must be present in the participant's service record:

- The IPOC, which documents the need for goods and services, and also identifies the goals that will be addressed with the purchases
- A written justification, which explains why the purchase of specific items or services would have a positive impact on treatment outcomes

SECTION 2 POLICIES AND PROCEDURES

WAIVER SERVICES

Documentation (Cont'd.)

- The budget formulated with IPOC documents that support the amount allocated
- An authorization signed by SCDHHS, approving the purchase of goods and services
- A paid invoice or receipt that provides evidence of purchase of the goods and/or services
- Documentation indicating the waiver participant received the items or services
- Documentation of discussions and purchases in the Case Management notes
- Documentation of the SPD team's discussions regarding goods and services received by the participant. This determines if the purchases are helping the participant work towards their goals in the IPOC.

Failure to show appropriate documentation regarding the purchase of goods and services will result in recoupment of Medicaid reimbursements.

Staff Requirements

The SPD team is responsible for determining if there is a continued need for Customized Goods and/or Services during the 90-day review of the IPOC. An SPD team member must meet the qualifications for the service they perform as a CHANCE Waiver provider.

Staff Training

SPD team members must be knowledgeable regarding the purpose, policy, and requirements involving the purchase of goods and services. SPD team members must understand their role in the process, and must also understand the requirements of a connection between the service or item being requested and the goal stated in the IPOC. There should be documentation of a training or team discussion regarding the goods and services policy.

INTENSIVE FAMILY SERVICES

Service Description

Intensive Family Services (IFS) are designed to utilize evidence-based interventions that assist CHANCE Waiver participants who have problem behaviors. The emphasis of IFS is on changing the social ecology of the participants and families to promote more positive treatment outcomes,

SECTION 2 POLICIES AND PROCEDURES

WAIVER SERVICES

Service Description (Cont'd.)

stronger family relationships, and decreased behavioral problems. IFS are pragmatic and goal-oriented treatment interventions that specifically target each factor in the participant's social network that contributes to his or her behaviors. Thus, IFS interventions typically aim to improve caregiver discipline practices, improve family relationships, decrease deviant behaviors, increase healthy peer relationships, improve school or vocational performances, engage participants in recreational activities, and develop a support network in the community where the participant and their family live. This network must consist of extended family, neighbors, and friends.

IFS support caregivers by teaching them how to maintain the techniques provided through the services. This promotes and facilitates positive behaviors and outcomes. By integrating therapies based on the specific needs of the participant and their family, IFS offers person- and family-centered individualized supports and linkage to available supports in coordination with the SPD team.

IFS is delivered in the participant and family's natural environment (home, foster home, school, community). The treatment decisions are decided in collaboration with family members and are family driven. The goal of IFS is to empower families to build a positive environment and network through the mobilization of natural resources available within the community.

Some of the core values and beliefs of IFS include:

- The belief that troubled families can change
- Families are colleagues of the IFS staff
- Families' beliefs and values must be respected
- A crisis is an opportunity to promote positive change
- Inappropriate interventions can do harm

The purpose of these services is to reinforce and enhance a participant's ability to function within the family and to enhance the family unit's level of functioning using a variety of interventions. Clinical interventions shall be designed to do the following:

- Reinforce and enhance the participant's ability to function within his or her home environment, and enhance the family's level of functioning

SECTION 2 POLICIES AND PROCEDURES

WAIVER SERVICES

Service Description (Cont'd.)

- Identify and assist the participant and their family in resolving conflicts
- Communicate and demonstrate methods of appropriate skills and/or behavior management techniques in order to help family members more effectively manage certain behaviors; or supporting/strengthening the participant's home environment
- Promote the family's relations with a social network that supports positive behavior
- Identify and address difficulties in the participant's peer relations and school performance
- Encourage the family to promote the participant's positive social relations and academic performance

IFS interventions can include the following components:

- Individual Therapy
- Family Therapy
- Crisis Intervention
- Substance Abuse Counseling (SAC)
- Other clinical interventions as needed based on the judgment of the IFS clinician

IFS is inclusive of therapy services available through the State Plan. When a participant is receiving IFS they are not eligible to receive other therapy services funded through Medicaid as this would be a duplication of services.

Eligibility

Individuals enrolled in the CHANCE Waiver can receive IFS as needed. Service needs are assessed, discussed, and determined by the SPD team. This team must include the waiver participants and their families. The demonstration of continued waiver eligibility must be documented in the participant's service record. IFS must be appropriately identified as a service in the budget and in the IPOC, and must be pre-authorized by CHANCE Waiver staff.

Billing Requirements

Billable activities are face-to-face, telephonic, or other direct interactions with the participant or their family. The intent of this service is face-to-face contact, but services

SECTION 2 POLICIES AND PROCEDURES

WAIVER SERVICES

Billing Requirements (Cont'd.)

may be provided by telephone under extenuating circumstances. The documentation must support extenuating circumstances that warrant telephonic contact.

IFS is billed in 30-minute units. The typical duration of IFS is 12 weeks with ongoing therapist-family contacts. Clinicians rendering IFS shall not exceed five child/family units in their caseload. SCDHHS staff may authorize services that extended past the 12-week period in extenuating circumstances. The need for continued services must be clearly documented in the 90-day summary and IPOC to justify extending IFS past the 12-week period.

A CHANCE Waiver provider must initiate services within 24 hours after he or she agrees to render services to the participant and their family.

IFS therapists must be available 24 hour per day/ 7 days per week to provide services when needed and to respond to crises. IFS is proactive and plans are developed to prevent or mitigate crises.

IFS must be pre-authorized by CHANCE Waiver staff before a provider can bill for services rendered. SCDHHS will purse recoupment of funds if they determine of a provider has billed for services inappropriately or if those services were not pre-authorized by CHANCE Waiver staff. IFS must be appropriately identified as a service in the budget and in the IPOC. Prior authorizations for IFS must be signed by CHANCE Waiver staff. CHANCE Waiver staff will authorize units based on the needs of the individual.

Documentation

In order for providers to be reimbursed by Medicaid, IFS must be listed in the current budget, the SCDHHS authorization, and in the IPOC.

Providers must be able to provide documentation in the form of a clinical note that includes the following information:

- The service is identified as Intensive Family Services
- Provider of the service
- Name and title of the person rendering the service

SECTION 2 POLICIES AND PROCEDURES

WAIVER SERVICES

Documentation (Cont'd.)

- Name, date of birth, and Medicaid ID number of the waiver participant
- Date the service was delivered
- Goal(s) addressed
- Clinical intervention
- Waiver participant response to clinical intervention
- Duration of services provided
- Signature of person rendering the service
- Date the note was written

All IFS activities must be documented. Some IFS activities are not billable activities but are an important part of coordinated care and must be documented in the clinical record.

The following activities are important functions, but are not billable services under the CHANCE Waiver:

- Participating in SPD
- Quality assurance reviews
- Communicating with the case manager or other service providers regarding progress
- Writing clinical notes to document IFS provided

Staff Requirements

Staff who render IFS must have one of the following credentials:

- Medical Doctor
- Licensed Master's level clinician
- Licensed Doctoral level

Staff must maintain their licensure and must meet other annual and enrollment requirements for CHANCE Waiver providers.

Staff training

Provider must ensure clinicians receive an overview of the CHANCE Waiver policy. Staff who render IFS must maintain the requirements for their clinical licensure.

SECTION 2 POLICIES AND PROCEDURES

WAIVER SERVICES

MEDICATION MONITORING AND WELLNESS EDUCATION SERVICES

Service Description

Medication Monitoring and Wellness Education services offer a variety of face-to-face or telephonic interventions to a waiver participant. Services may include:

- Assessing the need for participants to see a physician
- Determining the overt physiological effects related to medications
- Determining psychological effects of medications
- Monitoring participant's compliance with prescription directions
- Educating participants about dosages, frequencies, types, benefits, actions, and potential adverse effects of the prescribed medications
- Promoting health education regarding coexisting conditions that affect psychiatric symptomatology and functioning and promote participant competence. This intervention includes education about psychiatric medications and concurrent substance use in accordance with national practice guidelines and standards.
- Evaluating and determining the nutritional status of participants in support of improved treatment outcomes

Eligibility

Individuals enrolled in the CHANCE Waiver can receive Medication Monitoring and Wellness Education services as needed. Service needs are assessed, discussed, and determined by the SPD team. This team must include the waiver participants and their families. The demonstration of continued CHANCE Waiver eligibility must be documented in the participant's file. Medication Monitoring and Wellness Education must be appropriately identified as a service in the budget and in the IPOC. Services must be pre-authorized by CHANCE Waiver staff.

SECTION 2 POLICIES AND PROCEDURES

WAIVER SERVICES

Billing Requirements

In order to be eligible for Medicaid reimbursement, a qualified CHANCE Waiver provider must have an IPOC that authorizes Medication Monitoring and Wellness Education services to a waiver participant. The need for services must be documented in the IPOC. The IPOC must have been written within the past 90 days and must document the following: Medication Monitoring and Wellness Education listed as a service, provider agency, date service began, frequency, target date or duration, and goals for the provision of services. Services are billed in 30-minute units.

Billable activities are face-to-face, telephonic, or other direct contacts with the participant, and if needed, their family. The intent of this service is to provide face-to-face contact with the participant. However, services may be provided by telephone under extenuating circumstances. The documentation must support extenuating circumstances that warrant telephonic contact.

Medication Monitoring and Wellness Education services must be pre-authorized by CHANCE Waiver staff. SCDHHS will pursue recoupment of funds if they determine that a provider has billed for services inappropriately, or if those services were not pre-authorized by CHANCE Waiver staff. Medication Monitoring and Wellness Education must be appropriately identified as a service in the budget and in the IPOC. SCDHHS Waiver staff will authorize units based on the needs of the participant.

Documentation

In order for providers to be reimbursed by Medicaid for Medication Monitoring and Wellness Education, the service must be listed on the current budget, the SCDHHS CHANCE Waiver authorization, and in the IPOC.

Providers must be able to provide documentation in the form of a clinical note that includes the following information:

- The service is identified as a Medication Monitoring and Wellness Education service
- Provider of the service
- Name and title of the person rendering the service

SECTION 2 POLICIES AND PROCEDURES

WAIVER SERVICES

Documentation (Cont'd.)

- Name, date of birth, and Medicaid ID number of the waiver participant
- Date the service was delivered
- The goal(s)addressed
- Clinical intervention provided
- Waiver participant's response to clinical intervention
- The duration of services provided
- The signature of person rendering the service
- The date the note was written

When Medication Monitoring and Wellness Education includes monitoring the participant's medication, the following information must be included in the clinician's documentation:

- Medications the client is currently taking, or reference to the physician's order or another document in the medical record that lists all medications prescribed to the participant
- Side effects or adverse reactions experienced by the participant
- Whether the participant is refusing or unable to take medications as ordered, or is compliant in taking medications as prescribed
- How effective the medication(s) is in controlling symptoms
- Any issues related to concurrent substance use, documentation of education to the participant, and support for the rationale for continuing the necessary medication

All Medication Monitoring and Wellness Education activities must be documented. Some activities are not billable activities, but are an important part of coordinated care.

The following activities are important functions but are not billable services under the CHANCE Waiver:

- Participating in Service Plan Development

SECTION 2 POLICIES AND PROCEDURES

WAIVER SERVICES

Documentation (Cont'd.)

- Quality assurance reviews
- Communicating with the family, case manager, or other service providers regarding progress
- Writing clinical notes to document services provided

Staff Requirements

Staff who render Medication Monitoring and Wellness Education services must have one of the following credentials:

- Medical Doctor
- Advanced Practice Nurse
- Registered Nurse

Staff must maintain their licensure and meet other annual and enrollment requirements for CHANCE Waiver providers.

Staff training

Providers must ensure clinicians receive an overview of the CHANCE Waiver policy. Staff who render Medication Management and Wellness Education must maintain the appropriate training for their clinical licensure.

PEER SUPPORT SERVICES

Service Description

Peer Support Services provide an additional opportunity for the waiver participant and their family to receive person-centered support during the SPD process. The peer support specialist gives advice and guidance, provides insight, shares information on services, and empowers the participant to make healthy decisions. The unique relationship between the peer support specialist and the participant fosters understanding and trust in individuals who otherwise would be alienated from treatment. The participant's IPOC determines the focus of Peer Support Services.

Peer Support Services are comprised of two categories: Caregiver Peer Support and Youth Peer Support.

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WAIVER SERVICES

Caregiver Peer Support Services

Caregiver Peer Support Services are provided to the primary caregiver of the participant in the CHANCE Waiver program. This service is provided by individuals who:

- Have experience raising a child with SED
- Have knowledge of the behavioral health system in the State of South Carolina

Caregiver Peer Support Services are parent/guardian-centered with a focus on strengthening the caregiver's ability to cope and manage a child or youth with SED. Services allow caregivers the opportunity to direct their strengths and advocacy processes toward realizing appropriate behaviors for the participant. Sequentially, services promote skills for coping with and managing the participant's behavioral and emotional symptoms while facilitating the use of natural supports and community resources.

Caregiver Peer Support is a helping relationship between a parent and/or guardian and the caregiver peer support specialist. This relationship promotes respect, trust, and warmth; and it also empowers the participant's family to make changes and decisions to enhance their quality of life.

The caregiver peer support specialist encourages the parent and/or guardian to take a proactive approach to the activities and services offered within the treatment programs.

Youth Peer Support Services

Youth Peer Support services are provided by individuals who are currently in the behavioral health system, or those who were once clients within the system. Services are participant-centered with a focus on reducing behavioral challenges and coping with SED. Youth Peer Support develops a helping relationship between the participant and the youth peer support specialists to promote mutual respect and trust. Services are designed to help the participant make positive changes and decisions that will enhance their quality of life. The youth peer support specialist encourages participants to make decisions about the activities and services offered within their treatment program.

SECTION 2 POLICIES AND PROCEDURES

WAIVER SERVICES

Youth and Caregiver Peer Support Services

Youth and Caregiver Peer Support Services include:

- Providing education and information on the waiver processes
- Assisting with the development of the POC
- Identifying needs and establishing priorities
- Accessing current supports
- Partnering with professionals on the SPD team
- Overcoming service barriers
- Support concerning how to cope with stressors of the participant's disability
- Assisting with participant complaints
- Assisting with the waiver mediation and grievance processes
- Advocating on behalf of the participant or caregiver to ensure that their needs are being addressed within a reasonable time frame

Eligibility

Individuals enrolled in the CHANCE Waiver can receive Peer Support Services as needed. Service needs are assessed, discussed, and determined by the SPD team. This team must include the waiver participants and their families. The demonstration of continued waiver eligibility must be documented in the participant's file. Peer Support Services must be appropriately identified as a service in the budget, in the IPOC, and must be pre-authorized by CHANCE Waiver staff. CHANCE Waiver staff will authorize units based on the needs of the individual.

Billing Requirements

In order to be eligible for Medicaid reimbursement, a qualified CHANCE Waiver provider must have an IPOC that authorizes Peer Support Services to the waiver participant. The need for services must be documented in the IPOC. The IPOC must have been written within the past 90 days and must document the following: Peer Support listed as a service, provider agency, date service began, frequency, target date or duration, and goals for the provision of services.

Services must be pre-authorized by CHANCE Waiver staff before a provider can bill for services rendered to the

SECTION 2 POLICIES AND PROCEDURES

WAIVER SERVICES

Billing Requirements (Cont'd.)

participant. SCDHHS will pursue recoupment of funds if they determine a provider has billed for services inappropriately or if those services were not pre-authorized by CHANCE Waiver staff. Peer Support Services must be appropriately identified as a service in the budget, in the IPOC, and must be pre-authorized by CHANCE Waiver staff.

Peer Support Services are face-to-face interactions, which are billed in 15-minute units. CHANCE Waiver staff will authorize units based on the needs of the individual.

Documentation

In order for providers to be reimbursed by Medicaid for Peer Support Services, the service must be listed in the current budget, in the CHANCE Waiver authorization, and in the IPOC.

Providers must be able to provide documentation in the form of a service log that includes the following information:

- The service as either Youth or Caregiver Peer Support services
- Provider of the service
- Name and title of the person rendering the service
- Name of the waiver participant
- The name of the caregiver, if applicable
- Waiver participant's date of birth
- Waiver participant's Medicaid ID number
- Date the service was delivered
- Duration of services provided
- Signature of person rendering the service

Allowable activities for Peer Support Services include, but are not limited to:

- Attending a plan of care meeting to **advocate** for the wants and needs of the waiver participant and/or their family
- Discussing goals with the waiver participant and/or their family
- Discussing available service and support options with the SPD

SECTION 2 POLICIES AND PROCEDURES

WAIVER SERVICES

Documentation (Cont'd.)

The following activities are required functions of Peer Support providers but are not billable services under the CHANCE Waiver:

- Attendance at a POC meeting
- Quality assurance reviews
- Communicating with the case manager regarding the participant's progress

Staff Requirements

Caregiver Peer Support Specialist

A caregiver peer support specialist must be at least 21 years of age, possess a high school diploma or GED, and must have at least two years of personal experience raising a child with SED. This individual must have working knowledge of the South Carolina behavioral health system.

Youth Peer Support Specialist

A youth peer support specialist must have the skills and competencies necessary to render services, must successfully complete all training, and must be a former or current consumer of behavioral health services.

Peer Support Supervisor

A peer support supervisor must have **one** of the following qualifications:

- A master's degree in social work, psychology, counseling, special education, or in a closely related field
- A baccalaureate degree in social work, psychology, counseling, special education, or in a closely related field and have at least one year of experience performing clinical or case work activities
- A baccalaureate degree in an unrelated field of study and at least three years of experience performing clinical or case work activities
- A registered nurse licensed to practice in South Carolina and have at least three years of experience performing clinical or case work activities

SECTION 2 POLICIES AND PROCEDURES

WAIVER SERVICES

Staff Training

Peer Support training is required for all Youth and Caregiver Peer Support specialists. All newly hired Peer Support specialists must complete a training prior to having unsupervised contact with waiver participants. Peer Support specialists are also required to take annual refresher trainings. Providers are responsible for ensuring that each specialist is appropriately trained in accordance with CHANCE Waiver policy. Provider must show proof of annual training for the past three years for each specialist.

WRAPAROUND PARAPROFESSIONAL SERVICES

Service Description

Wraparound Paraprofessional services are defined as an array of community-based services designed to help stabilize, maintain, and strengthen the functioning level of seriously emotionally disturbed children and their families. The child may be at risk of placement in a more restrictive setting without the provision of these services. The treatment must be related to the improvement and/or maintenance of the child's level of functioning.

Wraparound Paraprofessional services are intended to prepare the participant with the necessary skills for learning how to be independent, avoiding negative behaviors, building positive relationships with people in their community, gaining confidence in their abilities, and appropriately communicating their needs with those around them—through participation in a variety of activities. Services are designed to educate the family on how to support the participant in reducing negative behaviors, gaining their independence, and interacting with others in their community.

Participants who need wraparound services can choose the service component(s) most appropriate for their treatment. The participant and their family will choose the qualified CHANCE Waiver providers who will be responsible for rendering each component of wraparound services.

Each component of wraparound services is listed separately on the budget and in the IPOC. The documentation must identify the provider of the service,

SECTION 2 POLICIES AND PROCEDURES

WAIVER SERVICES

Service Description (Cont'd.)

number of units authorized for each service component, and specific goals to be addressed by each service component.

Supervisors of Wraparound Paraprofessional staff must be available 24-hour per day/7-days per week, to assist with emergencies when services are being provided to participants. In addition, supervisors must be available to provide regular guidance and/or instruction to staff regarding treatment and progress.

CHANCE Waiver Wraparound Paraprofessional services include the following:

- Wraparound Behavioral Interventions
- Wraparound Independent Living Skills
- Wraparound Community Support Services
- Wraparound Caregiver Services

Wraparound Behavioral Interventions

Wraparound Behavioral Interventions are designed to optimize a participant's emotional and behavioral functioning in the community. Services are face-to-face interactions with the participants in a home- or community-based setting, and are used to address the participant's behavioral issues.

CHANCE Waiver providers of Wraparound Behavioral Intervention assist in the development of treatment plans that are designed to support the participants in building skills that will allow them to avoid negative behaviors.

Wraparound Behavioral Interventions are used to analyze a participant's dysfunctional behavior and to design specific techniques to support the family in reducing or eliminating undesired behaviors. Specific strategies are used to change, control, or manage adverse behavior. The primary focus of a behavioral intervention is to assist the participant in restructuring his or her milieu so that more positive treatment outcomes can be realized.

The treatment for dysfunctional behavior must be centered on the participant's emotional and/or developmental needs, and not solely on preventing disciplinary issues or avoiding the consequences of undesirable behaviors. Services provide the participant with the opportunity to alter existing behaviors, develop new or more appropriate behaviors, and function effectively within his or her

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WAIVER SERVICES

Wraparound Behavioral Interventions (Cont'd.)

environment. Behavioral interventions are accomplished through a one-on-one relationship between the participant and the Wraparound Paraprofessional staff, as they engage in a variety of structured activities.

Examples of appropriate interventions and/or treatment strategies may include shaping, extinction, redirection, and positive reinforcement.

Wraparound Independent Living Skills

Wraparound Independent Living Skills are individualized instructions and supportive services, which are provided face-to-face, and in a home- or community-based setting for participants who are, or will be, transitioning into independent living. Services are designed to assist participants in developing and/or restoring the necessary skills that they need to function independently in the community.

Examples of independent living skills include: budgeting, time management, problem-solving, prioritizing skills, communication and socialization skills, food planning and preparation, and maintenance of living environment.

Wraparound Community Support Services

Wraparound Community Support services are face-to-face interactions that provide the participant with the necessary skills to build relationships with people in their community, gain confidence in their abilities, and communicate their needs to those around them. Services support and stabilize participants in a community setting so that they will become successful in the least restrictive environment. Wraparound services are provided through face-to-face staff support in a community or in a group setting. A group setting can be a licensed after-school program or a summer camp.

The emphasis of Wraparound Community Support Services is on a strong therapeutic component, with treatment interventions integrated throughout the service time period. Interventions are designed to meet the goals in the participant's plan of care.

Wraparound Caregiver Services

Wraparound Caregiver services are face-to-face interactions provided to the primary caregiver through both formal and informal instructions. The interactions provide the caregiver with the skills needed to serve as the primary treatment agent, and to understand the needs and limitations of their child.

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WAIVER SERVICES

Eligibility

Individuals enrolled in the CHANCE Waiver can receive Wraparound Paraprofessional services, as needed. The need for services will be assessed, discussed, and determined by the SPD team. The SPD team must include the waiver participant and their family. The demonstration of continued waiver eligibility must be documented in the participant's file. Wraparound Paraprofessional services must be appropriately identified as a service on the budget and in the IPOC. Wraparound Paraprofessional services must be pre-authorized by CHANCE Waiver staff, who will authorize units based on the needs of the individual.

Billing Requirements

Billable Wraparound **must** be listed on the current budget, the SCDHHS authorization, and in the IPOC. The need for Wraparound Paraprofessional services must be documented in the IPOC, which must be written within the past 90-days. Additional documentation requirements for reimbursement are specified in the "Documentation" section, appearing below.

The IPOC, budget, and authorization must identify which components of Wraparound services are being requested for the participant. The documentation must identify the type of service as one of the following:

- Wraparound Behavioral Intervention
- Wraparound Independent Living Skills
- Wraparound Community Support
- Wraparound Caregiver Services

The documentation must also identify the provider agency, the date service began, frequency, target date or duration, and goals for the provision of Wraparound services.

The specific component of Wraparound Paraprofessional services must be identified on the budget, in the IPOC, and be pre-authorized by CHANCE Waiver staff in order to bill for services. Recoupment will be pursued for any discovery of a provider who billed for services inappropriately or services that were not authorized by CHANCE Waiver staff.

Billable Wraparound activities are face-to-face interactions with the participant or their family. Wraparound services are billed in 15-minute units. CHANCE Waiver staff will authorize units based on the needs of the individual.

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WAIVER SERVICES

Documentation

In order for providers to be reimbursed by Medicaid for Wraparound services, the service must be listed on the current budget, the CHANCE Waiver authorization, and in the IPOC.

Providers must provide documentation in the form of a service note that includes the following information:

- The service is identified as Wraparound Behavioral Intervention; Wraparound Independent Living Skills; Wraparound Community Support; or Wraparound Caregiver services
- Provider of the service
- Name and title of the person rendering the service
- Name, date of birth, and Medicaid ID number of the waiver participant
- Date the service was delivered
- The goal(s) addressed
- Staff action
- Waiver participant response to staff's action
- Duration of services provided
- Signature of person rendering the service
- Date the note was written

Some Wraparound service activities are not billable, but are an important part of coordinated care, and must be documented in the service record.

The following activities are important waiver functions, but are not billable services under the CHANCE Waiver:

- Attending POC meetings
- Quality assurance reviews
- Discussing progress with the case manager or family
- Completing administrative activities regarding the waiver participant's Wraparound services
- Other activities related to the SPD process or administrative activities

SECTION 2 POLICIES AND PROCEDURES

WAIVER SERVICES

Staff Requirements

All Wraparound service staff must be employed by a qualified waiver provider. Staff must have a high school diploma, or equivalent. A master's degree is required for all clinicians who are responsible for supervising Wraparound staff.

Staff Training

Wraparound Paraprofessional staff must complete all required training in order to render services. Providers must ensure that all employees continue to participate in required annual training in accordance with CHANCE Waiver and South Carolina Medicaid policy.

Accessing Other Services

Case managers are responsible for supporting waiver participants in their effort to access services and supports, regardless of the funding source. The case manager will provide the support needed to obtain the appropriate referrals. All services and supports must meet the participant's need to stay in the least restrictive environment, and contribute to behavioral health treatment, regardless of the funding source. The services and supports must be listed in the IPOC.

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WAIVER SERVICES

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SECTION 2 POLICIES AND PROCEDURES

DISCHARGE

REASONS FOR DISCHARGE

Waiver participants will be discharged from the waiver when it is determined that they no longer meet one of the following requirements:

- Have a Severe Emotional Disturbance (SED)
- Are between ages 4 and 19
- Have a need for waiver services
- Psychiatric Residential Treatment Facility (PRTF) Level of care eligibility determination requirements
- Financial eligibility for Medicaid services
- Service Plan Development (SPD) teams must develop a transition plan for waiver participants, prior to an individual being discharged from waiver services. The South Carolina Department of Health and Human Services (SCDHHS) will notify waiver participants of termination of their waiver services.

SERVICE SPECIFICS

During the SPD process, waiver participants may be discharged. If providers feel that a waiver participant is no longer appropriately eligible for the services they deliver, the providers can recommend discontinuation of that service to the SPD team, for further discussion and consideration.

Providers must discharge a waiver participant through the SPD team process. The only exception is when there is a health and/or safety risk for the waiver participant. In these instances, providers can suspend provisions for waiver services until the safety issues are addressed. **For Example:** A hypothetical waiver participant may become physically aggressive towards their respite staff. If the service program is not adequately staffed while the participant exhibits those behaviors, providers must immediately identify and communicate the risks to the participant's respective case manager. If this type of circumstance arises, the SPD team should determine how to best support the waiver participant and/or their family, if the participant is discharged from the service as a result of the health and/or safety risks that they posed.

SECTION 2 POLICIES AND PROCEDURES

DISCHARGE

INTERRUPTION

Waiver participants who are hospitalized, or who are in a PRTF for 30-days or more, will be discharged from the waiver. If a participant chooses not to receive waiver services for 30 or more days, they will be discharged from the waiver. In the event of special circumstances, waiver participants may request that the 30-day timeframe be extended. Participants are required to provide an explanation, which identifies their need for an extension. Extensions are given at the discretion of SCDHHS.

There may be instances when significant risks to waiver participants are identified, and when SPD teams cannot adequately support the participant and/or their family through home- and community-based supports and services. In these situations, participants may be placed in a hospital or PRTF to ensure the health and safety of the participants and their families. SPD teams should work closely with waiver participants and their families, and should anticipate the likelihood of potential crises among the participants. Ideally, the teams should have proactive supports and measures in place, in an effort to avoid the need for potential hospital or PRTF admissions. If a crisis presents serious health and/or safety risks that cannot be avoided, and hospitalization or PRTF placement is needed, participants may be admitted to a facility for up to 29-days without affecting their waiver eligibility. If a participant is admitted to a hospital or PRTF for 30-days or longer, they must be discharged from the waiver. Participants who were enrolled in the wavier service program within the past year, and who are transitioning out of a hospital or PRTF, can re-enroll in the waiver. However, those participants who have been discharged from the waiver for more than one year must re-apply for services. They must also wait until a waiver opening is available.

Waiver participants who are admitted to a hospital or PRTF, or those who temporarily choose to interrupt their services for less than 29-days, are not required to be discharged. Upon reinstating waiver services, the Individual Plan of Care (IPOC) does not need to be reviewed, unless the services are interrupted after the IPOC's end date. If an IPOC has expired, participants may return to waiver services based on the SPD team's review of the IPOCs. In order to ensure that required services are provided in a timely manner, desk reviews can be

SECTION 2 POLICIES AND PROCEDURES

DISCHARGE

INTERRUPTION (CONT'D.)

conducted by the case managers. This will allow waiver services to restart while SPD team meetings are scheduled. IPOC desk reviews must be submitted to SCDHHS, as required; and services must also be authorized. SPD teams must review IPOCs immediately following the participant's return to waiver services. This ensures that the waiver services plan remains valid, and continues to meet the needs of participants and/or their families.

INCREASE IN FUNCTIONING

Waiver participants, who no longer meet level of care requirements because of an increase in functioning, will be ensured that necessary supports are in place for them and their families. These supports will help participants gain success following the termination of their waiver services. Regular conversations during SPD team meetings should address the benchmarks that participants must reach, which will eventually lead to the reduction and elimination of their need for waiver services. Teams should be proactive regarding participant discharge. When participants no longer meet level of care requirements, SPD teams should already know what supports are needed for a successful discharge from the waiver.

FREEDOM OF CHOICE

If a participant and/or their family determine that they no longer want waiver services, they can discharge from the waiver, without prior notice. Whenever possible, SPD teams, case managers and/or the Federation of Families, should initiate discussions about the participant's decisions, and they should determine what supports are needed upon the participant's discharge from the waiver. Alternative supports and services should be discussed, as requested, with the waiver participants and/or their families. Appropriate referrals should be made, as requested, by the families. Participants and/or their families who do not accept supports from the SPD teams, case managers or the Federation of Families, and who also express an interest in immediate discharge, may do so.

AGING OUT

All waiver participants who are enrolled in the waiver at the time of their 19th birthday will be discharged from the waiver, as they will no longer be eligible to receive services through the waiver. Case managers are responsible for keeping track of those waiver participants who will approach age 19, in order to ensure that a transition plan is

SECTION 2 POLICIES AND PROCEDURES

DISCHARGE

AGING OUT (CONT'D.)

developed prior to a participant's 19th birthday. During the months prior to the waiver participant's 19th birthday, his/her family will be given information regarding the transition planning procedures. A family advocate will be available to meet and discuss the transition process with the participant's family. SCDHHS can provide the families with information about other State Plan services that might be available to waiver participants upon their discharge.

Three months prior to a participant's aging out of the waiver, the family's SPD team will meet to develop a transition plan. Case managers will be responsible for coordinating the transition team meetings. SCDHHS, the family advocacy organization, and the SPD teams will work with participants and/or their families to ensure that they are aware of, and have access to available services, which will support the participants upon their discharge from the waiver.

The transition IPOC must be signed by a case manager, as well as the waiver participant and/or their family. The signature(s) designate that they approve of the transition plan. After the meetings, case managers will make the appropriate referrals to ensure that the necessary supports and services are in place upon a participant's aging out of the waiver. The participant's transition IPOC shall specify which transitional services are pursued on their behalf, and shall also contain evidence that appropriate referrals/coordination has been initiated.

EXPIRATION OF THE WAIVER

SCDHHS will pursue home- and community-based supports and services, which will allow the agency to continue addressing the needs of participants who are enrolled in the 1915(c) PRTF Alternative CHANCE Waiver, once it expires on September 30, 2014. Each waiver participant remaining in the 1915(c) waiver, until its expiration, will have a transition plan to ensure that the appropriate supports and services are in place prior to a participant's discharge.