State of South Carolina
Department of Health and Human Services

Mark Sanford
Governor

Emma Forkner
Director

October 1, 2008

Ms. Mary Kay Justis
Acting Associate Regional Administrator
Centers for Medicare & Medicaid Services
Medicaid and SCHIP Policy Branch
Division of Medicaid and Children's Health
61 Forsyth Street, Suite, 4T20
Atlanta, George 30303-8909

ATTN: Ms. Kimberly Adkins-McCoy

Dear Ms. Justis:

On October 1, 2008, the South Carolina Department of Health and Human Services (SCDHHS) electronically submitted a 1915(c) waiver application to serve individuals with mental retardation or related disabilities through a Community Supports Waiver. We appreciate the guidance you have provided to SCDHHS and the SC Department of Disabilities and Special Needs to help us develop this waiver as a way to transition individuals currently receiving Medicaid State Plan rehabilitation services. Pending CMS approval of this new waiver, the State proposes to continue providing State Plan Rehabilitation services for an additional six months, through June 30, 2009, to have an orderly transition of participants into the waiver.

We greatly appreciate your guidance and continued support of CMS staff throughout this process, and we look forward to your review of this waiver application. Please contact Kara Lewis, (803) 898-2710, if you need additional information regarding the waiver document.

Sincerely,

Emma Forkner

Director

EF/mwmk

cc: Elaine Elmore
Rita Nimmons

Application for a §1915 (c) HCBS Waiver

HCBS Waiver Application Version 3.5

Submitted by:

Submission Date:	October 1, 2008

CMS Receipt Date *(CMS Use)*	

Provide a brief one-two sentence description of the request (e.g., renewal of waiver, request for new waiver, amendment) Include population served and broad description of the waiver program:

Brief Description:
This request is for a new waiver to serve South Carolinians with mental retardation/related disabilities whose waiver service needs will not exceed $10,986 per year. This amount may be adjusted in future years. This waiver will offer participants opportunities for participant/responsible party direction of the in-home support service.

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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

State:	
Effective Date	

1. Request Information

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

B. Waiver Title (*optional*): Community Supports

C. Type of Request *(select only one)*:

✓	**New Waiver (3 Years)**	CMS-Assigned Waiver Number (*CMS Use*):	
○	**New Waiver (3 Years) to Replace Waiver #** CMS-Assigned Waiver Number (*CMS Use*): *Attachment #1 contains the transition plan to the new waiver.*		
○	**Renewal (5 Years) of Waiver #**		
○	**Amendment to Waiver #**		

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

○	**Model Waiver**. In accordance with 42 CFR §441.305(b), the State assures that no more than 200 individuals will be served in this waiver at any one time.
✓	**Regular Waiver**, as provided in 42 CFR §441.305(a)

E.1 Proposed Effective Date: January 1, 2009

E.2 Approved Effective Date *(CMS Use)*:

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan *(check each that applies)*:

☐	Hospital *(select applicable level of care)*	
	○	Hospital as defined in 42 CFR §440.10. If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:
	○	Inpatient psychiatric facility for individuals under age 21 as provided in 42 CFR § 440.160
☐	Nursing Facility *(select applicable level of care)*	
	○	As defined in 42 CFR §440.40 and 42 CFR §440.155. If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:
	○	Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140
✓	Intermediate Care Facility for the Mentally Retarded (ICF/MR) (as defined in 42 CFR §440.150). If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/MR facility level of care:	

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

☐	Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I			
☐	Waiver(s) authorized under §1915(b) of the Act. *Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:*			
	Specify the §1915(b) authorities under which this program operates (*check each that applies*):			
	☐	§1915(b)(1) (mandated enrollment to managed care)	☐	§1915(b)(3) (employ cost savings to furnish additional services)
	☐	§1915(b)(2) (central broker)	☐	§1915(b)(4) (selective contracting/limit number of providers)
☐	A program operated under §1932(a) of the Act. *Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved.*			
☐	A program authorized under §1915(i) of the Act			
☐	A program authorized under §1915(j) of the Act			
☐	A program authorized under §1115 of the Act. *Specify the program:*			
✓	Not applicable			

2. Brief Waiver Description

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

The purpose of this waiver is to serve people with mental retardation or related disabilities whose waiver service needs will not exceed $10,986 per year.

The yearly amount may be adjusted in future years. All participants will meet ICF/MR level of care criteria. The state proposes to offer opportunities for participant direction for in-home support services. Administrative authority for this waiver will be retained by the South Carolina Department of Health and Human Services (DHHS). The South Carolina Department of Disabilities and Special Needs (DDSN) will perform waiver operations under a Memorandum of Agreement (MOA) and service contract with DHHS. DDSN will have the operational responsibility for ensuring that participants are aware of their options under this waiver. DDSN utilizes an organized health care delivery system that includes both county Disability and Special Needs (DSN) Boards and private providers as waiver service providers.

The services offered in this waiver are meant to prevent and/or delay institutionalization. This waiver reflects the State's commitment to offer viable community options to institutional placement. This waiver will also be used to transition persons receiving rehabilitative supports under the SC Medicaid State Plan. This transition is a part of the efforts under SC-08-014.

3. Components of the Waiver Request

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

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

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

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

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

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

✓	The waiver provides for participant direction of services. *Appendix E is required*.
○	Not applicable. The waiver does not provide for participant direction of services. *Appendix E is not completed*.

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

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

H. Quality Improvement Strategy. **Appendix H** contains the overall systems improvement for this waiver.

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

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

4. Waiver(s) Requested

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

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

○	Yes
✓	No
○	Not applicable

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

○	**Yes** *(complete remainder of item)*
✓	**No**

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

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

5. Assurances

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

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

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,
3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.

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

C. Evaluation of Need: The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less)

but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

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

1. Informed of any feasible alternatives under the waiver; and,
2. Given the choice of either institutional or home and community-based waiver services.

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

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

F. Actual Total Expenditures: The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

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

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

I. Habilitation Services. The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Improvement Act of 2004 (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

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

6. Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected amount, frequency and duration and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including

State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

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

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

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

E. Free Choice of Provider. In accordance with 42 CFR §431.51, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

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

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

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

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

Meetings were held with stakeholders including likely participants for input into the waiver design. A public meeting was held September 3, 2008 with all interested parties. Approximately 50 persons attended this meeting and were offered the opportunity to provide feedback. Additionally, the State offered the opportunity for the submission of written comments. Submission of the waiver was approved by DHHS's Medical Care Advisory Committee (MCAC) on August 19, 2008.

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

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

7. Contact Person(s)

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

First Name:	Kara
Last Name	Lewis
Title:	Program Coordinator
Agency:	South Carolina Department of Health and Human Services
Address 1:	PO Box 8206
Address 2:	
City	Columbia
State	SC
Zip Code	29202
Telephone:	(803) 898-2710
E-mail	Lewis@scdhhs.gov
Fax Number	(803) 255-8209

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

First Name:	Janet
Last Name	Priest
Title:	Director, Mental Retardation Division
Agency:	South Carolina Department of Disabilites and Special Needs
Address 1:	PO Box 4706
Address 2	
City	Columbia
State	SC
Zip Code	29240
Telephone:	(803) 898-9620
E-mail	jpriest@ddsn.sc.gov

Fax Number	(803) 898-9660

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the State's request for a waiver under §1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.

Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature: _____ **Date:**

State Medicaid Director or Designee

First Name:	Emma
Last Name	Forkner
Title:	Director
Agency:	South Carolina Department of Health and Human Services
Address 1:	PO Box 8206
Address 2:	
City	Columbia
State	SC
Zip Code	29202
Telephone:	(803) 898-2504
E-mail	Forkner@scdhhs.gov
Fax Number	(803) 898-4515

Appendix A: Waiver Administration and Operation

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

○	The waiver is operated by the State Medicaid agency. Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program (*select one;*:		
	○	The Medical Assistance Unit *(name of unit) (do not complete Item A-2*):	
	○	Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit (name of division/unit). This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency. (*Complete item A-2-a):*	
✓	The waiver is operated by **The Department of Disabilities and Special Needs** a separate agency of the State that is not a division/unit of the Medicaid agency. In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. (*Complete item A-2-b).*		

2. **a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities.

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

requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

DHHS and DDSN have a Memorandum of Agreement (MOA) to ensure an understanding between agencies regarding the operation and administration of the waiver. The MOA delineates the waiver will be operated by DDSN under the supervision of DHHS, whom will exercise administrative discretion in the administration and supervision of the waiver, and issue policies, rules, and regulations pertaining to the waiver. DHHS is the final authority and makes all final decisions regarding all matters related to the administration of the waiver. The MOA specifies the following delegated waiver functions between both agencies:

- Communication
- Coordination
- Level of Care
- Quality Management
- Medicaid Management Information System
- Fiscal Administration

The MOA is reviewed and updated at least every three (3) years and amended as needed.

DHHS and DDSN also have a service contract outlining the requirements and responsibilities for the provision of waiver services by the operating agency. This contract clarifies the following:

- Waiver service definitions
- Provider qualifications
- Waiver service reimbursement rates
- Conditions for reimbursement

The service contract is reviewed and updated at least every three (3) years and amended as needed.

DHHS utilizes various quality assurance methods to evaluate the operating agency's compliance with the terms and conditions established in the MOA and service contract, with special focus on DDSN's performance of assigned waiver operational and administrative functions in accordance with waiver requirements. DHHS uses a Quality Improvement Organization (QIO), quality assurance staff, and other agency staff to continuously evaluate the operating agency's quality management processes to ensure compliance. The following describes the roles of each entity:

CMS Approved QIO: Conducts monthly validation reviews of a representative sample of initial level of care determinations performed by DDSN. Monthly reports are produced and shared with DDSN, who is responsible for remedial actions as necessary in a timely manner. Quarterly summary reports are also created with trending and analysis of data, and recommendations for improvement.

QA Staff: Conducts periodic quality assurance and compliance validation reviews of a sample of participant case records and personnel files of DDSN service providers. These reviews focus on the CMS quality assurance indicators and performance measures.

A report of findings is provided to DDSN, who is required to develop and implement a remediation plan, if applicable in a timely manner.

QA staff utilize other systems such as Medicaid Management Information Systems (MMIS) and MedStat Advantage to monitor quality and compliance with waiver standards. The use and results of these discovery methods may require special focus reviews. In such instances, a report of findings is provided to the operating agency for remediation purposes.

Other DHHS Staff: Conducts utilization reviews, investigate potential fraud, and other requested focused reviews of the operating agency as warranted. A report of findings is produced and provided to DDSN for remedial action(s) as necessary.

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

✓	**Yes.** Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable). Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.*
	DDSN contracts with, a CMS certified QIO for oversight and review of waiver services and providers participating in DDSN operated waivers. DHHS contracts with a CMS certified QIO, to review a representative sample of ICF/MR levels of care determined by DDSN. This entity provides monthly reports and quarterly summaries of the outcome of their review process. DDSN contracts with the University of South Carolina Center for Disability Resources which will provide resources for participant assistance with the self-directed service of In-Home Supports. DDSN contracts with the Jasper DSN Board which is responsible for verifying the qualifications of and payment for all In-Home Support service providers.
○	**No**. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).

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

✓	**Local/Regional non-state public agencies** conduct waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state agency that sets forth the responsibilities and performance requirements of the local/regional agency. The interagency agreement or memorandum of understanding is available through the Medicaid agency or the operating agency (if applicable). *Specify the nature of these agencies and complete items A-5 and A-6:*
	DHHS will have an MOA with DDSN for the operation of the Community Supports Waiver. DDSN will contract with its qualified service providers for Plan of Service development and waiver service provision. Jasper DSN board is responsible for verifying the qualifications of and payment for all In-Home Support providers.
✓	**Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a **contract** between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The contract(s) under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable). *Specify the nature of these entities and complete items A-5 and A-6*:
	DDSN will contract with its qualified service providers for Plan of Service development and waiver service provision.
☐	**Not applicable** – Local/regional non-state agencies do not perform waiver operational and administrative functions.

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

DDSN will assess the performance of its contracted local/regional non-state entities responsible for conducting waiver operational functions. The Jasper DSN Board will operate as the fiscal agent for participant directed services. DDSN will contract with DSN Boards and other qualified/approved providers and assess these providers annually.

DHHS Quality Assurance (QA) staff will conduct validation reviews of the waiver operational functions performed by DDSN and any of its contracted local/regional non-state entities, in addition to assessing the performance of contracted entities in conducting waiver administrative functions. Additionally, upon request, *DHHS Medicaid Program Integrity (MPI) Unit* conducts reviews.

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver

operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

The DHHS/DDSN MOA will set forth both the operational agency responsibility for QA and the administering agency oversight of the QA process.

DDSN will assess the performance of its contracted and local/regional non-state entities responsible for conducting waiver operational functions. DDSN will contract with a provider of QA and quality performance to assess the local DSN Boards and other providers on an annual basis. DDSN Central Office will also conduct reviews and provide technical assistance to the local DSN Boards, and provide DHHS reports of such reviews and technical assistance in a timely manner. Additionally, DDSN Internal Audit Division will conduct internal audit reviews of the local network of DSN Boards and other approved providers. The local DSN Boards are required to have a financial audit conducted annually by a CPA firm that is chosen by the Boards, and all results related to waiver participants will be shared with DHHS in a timely manner. DDSN Internal Audit Division will also conduct special request audits, investigate fraud cases, provide training and technical assistance, and review the audited financial statements of the local DSN Boards. All findings will be shared with DHHS in a timely manner. DDSN Internal Audit Division will conduct a review of the contracted fiscal agent, and likewise, all findings related to waiver participants will be shared with DHHS in a timely manner.

DDSN's QIO will also assess the local DSN Boards and other qualified/approved providers through DDSN at least annually. The QIO will also conduct follow-up reviews of the local DSN Boards and other approved providers. A comprehensive Report of Findings will be issued by the QIO to the local DSN Board provider and to DDSN. DDSN will share the Report of Findings with the administrative agency in a timely manner. DDSN's QIO will also complete an annual mail-out survey (family surveys) to supplement the quality review process. These results will also be shared with the administrative agency in a timely manner.

DHHS will utilize its QA staff, *MPI Unit*, and QIO to oversee and review the operational functions of DDSN. DHHS will conduct QA validation reviews of DDSN providers at least annually or more often as needed. Findings will be submitted to DDSN Central Office for review and remediation as warranted. DDSN Central Office will review the findings with its providers and provide technical assistance and follow up action as necessary. DHHS will also review DDSN's QIO annual mail-out survey results and suggest remedial action(s) as warranted.

DHHS will review DDSN Internal Audit Division annual reports, special request audits, and fraudulent case investigations and suggest remedial action(s) as determined necessary.

Additionally, DHHS will review DDSN's QIO Reports of Findings and conduct independent QA validation reviews to confirm the findings on at least an annual basis. Upon request, *DHHS MPI Unit* will conduct reviews. Follow-up to the MPI reviews will be conducted as necessary based on the Report of Findings.

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct an administrative function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
Participant waiver enrollment	✓	✓	✓	✓
Waiver enrollment managed against approved limits	✓	✓	✓	✓
Waiver expenditures managed against approved levels	✓	✓	✓	✓
Level of care evaluation	✓	✓	✓	✓
Review of Participant service plans	✓	✓	✓	✓
Prior authorization of waiver services	✓	✓	✓	✓
Utilization management	✓	✓	✓	✓
Qualified provider enrollment	✓	✓	✓	☐
Execution of Medicaid provider agreements	✓	✓	✓	☐
Establishment of a statewide rate methodology	✓	☐	☐	☐
Rules, policies, procedures and information development governing the waiver program	✓	✓	☐	☐
Quality assurance and quality improvement activities	✓	✓	✓	✓

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

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

a.i For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

Performance Measure:	*Presence of an MOA that includes designated functions.*		
Data Source [e.g. – examples cited in IPG]	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
DHHS/DDSN MOA document	✓ *State Medicaid Agency*	☐ *Weekly*	✓ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample;*
	☐ *Other: Specify:*	☐ *Annually*	
		✓ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		✓ *Other: Specify:*	
		Every 3 years or more often as needed	☐ *Other: Describe*

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

Add another Performance measure (button to prompt another performance measure)

Performance Measure:	*Presence of a service contract that includes requirements and responsibilities for the provision of services.*		
Data Source [e.g. – examples cited in IPG]	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
DHHS/DDSN service contract	✓ *State Medicaid Agency*	☐ *Weekly*	✓ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample;*
	☐ *Other: Specify:*	☐ *Annually*	
		✓ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		✓ *Other: Specify:*	
		Every 3 years or more often as needed	☐ *Other: Describe*
Data Aggregation and Analysis	***Responsible Party for data aggregation and analysis*** *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*	
	✓ *State Medicaid Agency*	☐ *Weekly*	
	☐ *Operating Agency*	☐*Monthly*	
	☐ *Sub-State Entity*	✓ *Quarterly*	
	☐ *Other: Specify:*	☐ *Annually*	

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

Add another Performance measure (button to prompt another performance measure)

Performance Measure:	*Proportion of ICF/MR level of care validation reviews.*		
Data Source [e.g. – examples cited in IPG]	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
Qualis Health reports	✓ *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	☐ *Operating Agency*	✓ *Monthly*	✓ *Less than 100% Review*
	☐ *Sub-State Entity*	✓ *Quarterly*	✓ *Representative Sample;*
	✓ *Other: Specify:*	✓ *Annually*	*5%*
	Qualis Health	☐ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	
			☐ *Other: Describe*
Data Aggregation and Analysis	***Responsible Party for data aggregation and analysis*** *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*	
	✓ *State Medicaid Agency*	☐ *Weekly*	
	☐ *Operating Agency*	✓ *Monthly*	
	☐ *Sub-State Entity*	✓ *Quarterly*	
	✓ *Other: Specify:*	✓ *Annually*	
	Qualis Health	☐ *Continuously and Ongoing*	
		☐ *Other: Specify:*	

Add another Performance measure (button to prompt another performance measure)

Performance Measure:	*Proportion of quality assurance and compliance validation reviews.*

Data Source [e.g. – examples cited in IPG]	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
DHHS Report of Findings	✓ *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	✓ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	✓ *Representative Sample;*
	☐ *Other: Specify:*	☐ *Annually*	*10%*
		✓ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	
			☐ *Other: Describe*
Data Aggregation and Analysis	***Responsible Party for data aggregation and analysis*** *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*	
	✓ *State Medicaid Agency*	☐ *Weekly*	
	☐ *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	☐ *Annually*	
		✓ *Continuously and Ongoing*	
		☐ *Other: Specify:*	

Add another Performance measure (button to prompt another performance measure)

Performance Measure:	*Proportion of special focus reviews, utilization reviews, and/or fraud investigations.*		
Data Source [e.g. – examples cited in IPG]	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
DHHS Report of Findings	✓ *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative*

			Sample;
	☐ *Other: Specify:*	☐ *Annually*	
		✓ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		✓ *Other: Specify:*	
		Reviews and/or investigations are conducted as warranted	✓ *Other: Describe*
			Sampling is determined by evidence warranting a special review and/or investigation
Data Aggregation and Analysis	***Responsible Party for data aggregation and analysis*** *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*	
	✓ *State Medicaid Agency*	☐ *Weekly*	
	☐ *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	✓ *Annually*	
		✓ *Continuously and Ongoing*	
		☐ *Other: Specify:*	

Add another Performance measure (button to prompt another performance measure)

Performance Measure:	*Aggregated discovery and remediation reports submitted by the operating agency, relating to each of the operating agency's performance measures, for all CMS assurances are reviewed and addressed if applicable.*		
Data Source [e.g. – examples cited in IPG]	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
DDSN Reports	✓ *State Medicaid Agency*	☐ *Weekly*	✓ *100% Review*
	✓ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	✓ *Quarterly*	☐ *Representative Sample;*
	☐ *Other: Specify:*	✓ *Annually*	
		✓ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	

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

Performance Measure:	*Meetings are held with the operating agency to discuss specific waiver issues (i.e., review of aggregated reports).*		
Data Source [e.g. – examples cited in IPG]	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
DHHS/DDSN Agendas	✓ *State Medicaid Agency*	☐ *Weekly*	✓ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	✓ *Quarterly*	☐ *Representative Sample;*
	☐ *Other: Specify:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		✓ *Other: Specify:*	
		Every other month and/or more often as warranted	☐ *Other: Describe*
Data Aggregation and Analysis	***Responsible Party for data aggregation and analysis*** *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*	
	✓ *State Medicaid Agency*	☐ *Weekly*	
	☐ *Operating Agency*	☐*Monthly*	

	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	☐ *Annually*	
		✓ *Continuously and Ongoing*	
		☐ *Other: Specify:*	

Performance Measure:	*Policy changes are discussed with and/or communicated to the operating agency in a timely manner.*		
Data Source [e.g. – examples cited in IPG]	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
DHHS Memo	✓ *State Medicaid Agency*	☐ *Weekly*	✓ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample;*
	☐ *Other: Specify:*	☐ *Annually*	
		✓ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	
			☐ *Other: Describe*
Data Aggregation and Analysis	***Responsible Party for data aggregation and analysis*** *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*	
	✓ *State Medicaid Agency*	☐ *Weekly*	
	☐ *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	☐ *Annually*	
		✓ *Continuously and Ongoing*	
		☐ *Other: Specify:*	

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

DHHS evaluates the CMS assurances through a QA process that allows various findings to be utilized in an efficient manner to identify and address areas of major concern, to identify the need for policy clarifications/amendments, remedial actions, and provider compliance. This allows the QA staff and QIO entity to perform focus reviews and develop trending reports to assure all participants are served fairly and equitably based on Medicaid policies and procedures. These methods also allow DHHS to regularly discuss and analyze the results of all findings/collected data to ensure participants' outcomes and experiences are continuously beneficial.

b. Methods for Remediation/Fixing Individual Problems

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

The DHHS QIO produces monthly and quarterly reports of findings based on level of care validation reviews. These reports are shared with the operating agency, who is responsible for addressing all identified issues through a remediation plan, which may include training, policy corrections, or financial adjustments for Federal Financial Participation.

The DHHS QA staff produces a report of findings, which is also shared with the operating agency. The report of findings discusses issues such as untimely level of care re-evaluations, incomplete service plans, and/or incorrect billings to Medicaid. The operating agency is responsible for developing and implementing remedial actions to prevent future occurrences of the same issues.

All identified issues and plans of remediation are kept in a master file by the DHHS QA staff to consistently evaluate the quality improvement initiatives of the operating agency.

b.ii Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)	***Responsible Party*** *(check each that applies)*	***Frequency of data aggregation and analysis:*** *(check each that applies)*
[redacted]	✓ *State Medicaid Agency*	☐ *Weekly*
[redacted]	☐ *Operating Agency*	☐ *Monthly*
[redacted]	☐ *Sub-State Entity*	☐ *Quarterly*
[redacted]	☐ *Other: Specify:*	☐ *Annually*
[redacted]		✓ *Continuously and Ongoing*
[redacted]		☐ *Other: Specify:*
[redacted]		

c. Timelines

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

○	**Yes** *(complete remainder of item)*
✓	**No**

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

Appendix B: Participant Access and Eligibility

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

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

Select one Waiver Target Group		Target Group/Subgroup	Minimum Age	Maximum Age	
				Maximum Age Limit: Through age –	No Maximum Age Limit
○	**Aged or Disabled, or Both** *(select one)*				
	○	**Aged or Disabled or Both – General** *(check each that applies)*			
	☐	Aged (age 65 and older)			☐
	☐	Disabled (Physical) (under age 65)			
	☐	Disabled (Other) (under age 65)			
	○	**Specific Recognized Subgroups** *(check each that applies)*			
	☐	Brain Injury			☐
	☐	HIV/AIDS			☐
	☐	Medically Fragile			☐
	☐	Technology Dependent			☐
✓	**Mental Retardation or Developmental Disability, or Both** *(check each that applies)*				
	☐	Autism			☐
	☐	Developmental Disability			☐
	✓	Mental Retardation	0		✓
○	**Mental Illness** *(check each that applies)*				
	☐	Mental Illness (age 18 and older)			☐
	☐	Mental Illness (under age 18)			

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

Persons with Related Disabilities defined as:

"Related disability" is a severe, chronic condition found to be closely related to mental retardation and must meet the four following conditions:

- It is attributable to cerebral palsy, epilepsy, autism or any other condition other than mental illness found to be closely related to mental retardation because this condition results in impairment similar to that of persons with mental retardation and requires treatment or services similar to those required for these persons.
- It is manifested before twenty-two years of age.
- It is likely to continue indefinitely.
- It results in substantial functional limitations in three or more of the following areas of major life activity: self-care, understanding and use of language, learning, mobility, self-direction and capacity for independent living.

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

✓	Not applicable – There is no maximum age limit
○	The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit (*specify*):

Appendix B-2: Individual Cost Limit

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

○	**No Cost Limit**. The State does not apply an individual cost limit. *Do not complete Item B-2-b or Item B-2-c*.
○	**Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c*. The limit specified by the State is *(select one)*:
○	%, a level higher than 100% of the institutional average
○	Other *(specify)*:
○	**Institutional Cost Limit**. Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c*.
✓	**Cost Limit Lower Than Institutional Costs**. The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver. *Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c*.
	$10,986 per year. The State has analyzed the service plans of potential participants to determine the kinds and amounts of services likely to be needed. Based on that analysis, this limit will be sufficient to assure the health and welfare of participants.
	The cost limit specified by the State is *(select one)*:
✓	The following dollar amount: $ 10,986
	The dollar amount *(select one)*:
✓	Is adjusted each year that the waiver is in effect by applying the following formula:
	Adjustments will be made based on mandated service rate changes and/or legislative cost of living adjustments and/or other legislative mandates.
○	May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.
○	The following percentage that is less than 100% of the institutional average: %
○	Other – *Specify:*

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

The needs of the applicant will be assessed by the service coordinator, and services to address those needs will be determined in a plan of care. A centralized approval process will ensure that entrance will be granted only when costs do not exceed the limit and health and welfare can be assured.

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

☐	The participant is referred to another waiver that can accommodate the individual's needs.
✓	Additional services in excess of the individual cost limit may be authorized. Specify the procedures for authorizing additional services, including the amount that may be authorized:
	In the event of a short-term, unanticipated, urgent change in the waiver participant's needs, the individual cost limit of this waiver may be exceeded by up to $3,000. Requests for exceeding the cost limit will be submitted to the Operating Agency for review and approval. Otherwise, participants whose anticipated, long term/ongoing needs will exceed the individual cost limit will be referred to the State's Mental Retardation/Related Disabilities (MR/RD) Waiver. The State's policy will allow participants of the Community Supports Waiver whose anticipated, long term/ongoing needs will exceed the individual cost limit to by-pass the waiting list and enter the waiver in order to avoid an adverse impact on the participant.
☐	Other safeguard(s) *(specify)*:

Appendix B-3: Number of Individuals Served

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

Table: B-3-a	
Waiver Year	Unduplicated Number of Participants
Year 1	2530
Year 2	3630
Year 3	3960
Year 4 (renewal only)	
Year 5 (renewal only)	

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

○	The State does not limit the number of participants that it serves at any point in time during a waiver year.
✓	The State limits the number of participants that it serves at any point in time during a waiver year. The limit that applies to each year of the waiver period is specified in the following table:

Table B-3-b	
Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	2300
Year 2	3300
Year 3	3600
Year 4 (renewal only)	
Year 5 (renewal only)	

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

○	**Not applicable**. The state does not reserve capacity.
✓	The State reserves capacity for the following purpose(s). For each purpose, describe how the amount of reserved capacity was determined:
	To serve those currently receiving State Plan Rehabilitation services. The reserved capacity was determined based on the number currently served through the Rehabilitation option. To serve those currently enrolled in the Mental Retardation/Related Disabilities (MR/RD) Waiver who choose to be enrolled in this waiver. This number was based on the estimated number of MR/RD Waiver participants who may choose to enter this waiver.
	The capacity that the State reserves in each waiver year is specified in the following table:

Table B-3-c

Waiver Year	Purpose: Those receiving State Plan Rehabilitation Services — Capacity Reserved	Purpose: Those enrolled in the MR/RD Waiver who choose to enroll in this waiver. — Capacity Reserved
Year 1	2000	300
Year 2		1000
Year 3		300
Year 4 (renewal only)		
Year 5 (renewal only)		

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

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

e. Allocation of Waiver Capacity. *Select one:*

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

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

The Community Supports Waiver includes reserved capacity for two (2) groups of people, those with Mental Retardation/Related Disabilities who receive State Plan Rehabilitation Services and those with Mental Retardation/Related Disabilities who are participants in the State's Mental Retardation/Related Disabilites Waiver. Upon discharge from Rehabilitation Supports or disenrollment from the MR/RD Waiver, applicants may enroll directly into the Community Supports Waiver without being subjected to any existing waiting list.

When capacity, other than that which is reserved, is not available, applicants' names will be placed on a statewide waiting list. This list will be maintained and slots will be awarded on a first come first served basis.

Attachment #1 to Appendix B-3

Waiver Phase-In/Phase Out Schedule

a. The waiver is being *(select one)*:

✓	Phased-in
○	Phased-out

b. **Waiver Years Subject to Phase-In/Phase-Out Schedule** *(check each that applies)*:

Year One	Year Two	Year Three	Year Four	Your Five
✓	☐	☐	☐	☐

c. **Phase-In/Phase-Out Time Period**. *Complete the following table:*

	Month	Waiver Year
Waiver Year: First Calendar Month	January	
Phase-in/Phase out begins	January	2009
Phase-in/Phase out ends	August	2009

d. **Phase-In or Phase-Out Schedule**. *Complete the following table:*

Phase-In or Phase-Out Schedule			
	Waiver Year:	Beginning January 2009	
Month	Base Number of Participants	Change in Number of Participants	Participant Limit
January	0	235	235
February	235	145	380
March	380	400	780
April	780	200	980
May	980	210	1190
June	1190	435	1625
July	1625	255	1880
August	1880	420	2300
September	2300	0	2300
October	2300	0	2300
November	2300	0	2300
December	2300	0	2300

Appendix B-4: Medicaid Eligibility Groups Served in the Waiver

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

✓	§1634 State
○	SSI Criteria State
○	209(b) State

a-2. Miller Trust State.

Indicate whether the State is a Miller Trust State.

✓	Yes
○	No

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

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)			
✓	Low income families with children as provided in §1931 of the Act		
✓	SSI recipients		
☐	Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121		
✓	Optional State supplement recipients		
✓	Optional categorically needy aged and/or disabled individuals who have income at: *(select one)*		
	✓	100% of the Federal poverty level (FPL)	
	○	%	of FPL, which is lower than 100% of FPL
○	Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)		
☐	Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)		
☐	Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)		
✓	Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)		
☐	Medically needy in 209(b) States (42 CFR §435.330)		
☐	Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)		
✓	Other specified groups (include only the statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver) *specify*:		

	All other mandatory or optional groups under the State Plan.

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

○	**No**. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. Appendix B-5 is not submitted.
✓	**Yes**. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. *Select one and complete Appendix B-5*.
✓	All individuals in the special home and community-based waiver group under 42 CFR §435.217
○	Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217 *(check each that applies)*:
○	A special income level equal to (select one):
○	300% of the SSI Federal Benefit Rate (FBR)
○	% of FBR, which is lower than 300% (42 CFR §435.236)
○	$ which is lower than 300%
☐	Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)
☐	Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)
☐	Medically needy without spend down in 209(b) States (42 CFR §435.330)
☐	Aged and disabled individuals who have income at: *(select one)*
○	100% of FPL
○	% of FPL, which is lower than 100%
☐	Other specified groups (include only the statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver) *specify*:

Appendix B-5: Post-Eligibility Treatment of Income

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group. A State that uses spousal impoverishment rules under §1924 of the Act to determine the eligibility of individuals with a community spouse may elect to use spousal post-eligibility rules under §1924 of the Act to protect a personal needs allowance for a participant with a community spouse.

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

✓		Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the State elects to (*select one*):
	✓	Use *spousal* post-eligibility rules under §1924 of the Act. *Complete ItemsB-5-b-2 (SSI State and §1634) or B-5-c-2 (209b State) and Item B-5-d.*
	○	Use *regular* post-eligibility rules under 42 CFR §435.726 (SSI State and §1634) (*Complete Item B-5-b-1*) or under §435.735 (209b State) (*Complete Item B-5-c-1). Do not complete Item B-5-d.*
○		Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse. *Complete Item B-5-c-1 (SSI State and §1634) or Item B-5-d-1 (209b State). Do not complete Item B-5-d.*

NOTE: Items B-5-b-1 and B-5-c-1 are for use by states that do not use spousal eligibility rules or use spousal impoverishment eligibility rules but elect to use regular post-eligibility rules.

b-1. Regular Post-Eligibility Treatment of Income: SSI State and §1634 State. The State uses the post-eligibility rules at 42 CFR §435.726. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. <u>Allowance for the needs of the waiver participant</u> (*select one*):				
☐	The following standard included under the State plan *(select one)*			
	○	SSI standard		
	○	Optional State supplement standard		
	○	Medically needy income standard		
	○	The special income level for institutionalized persons *(select one):*		
		○	300% of the SSI Federal Benefit Rate (FBR)	
		○	%	of the FBR, which is less than 300%
		○	$	which is less than 300%.
	○	%		of the Federal poverty level
	○	Other standard included under the State Plan (specify):		

State:	
Effective Date	

○	The following dollar amount:	$	If this amount changes, this item will be revised.
○	The following formula is used to determine the needs allowance:		
○	Other (specify):		

ii. <u>Allowance for the spouse only</u> (*select one*):

○	SSI standard		
○	Optional State supplement standard		
○	Medically needy income standard		
○	The following dollar amount:	$	If this amount changes, this item will be revised.
○	The amount is determined using the following formula:		
○	Not applicable *(see instructions)*		

iii. <u>Allowance for the family</u> *(select one)*:

○	AFDC need standard		
○	Medically needy income standard		
○	The following dollar amount:	$	The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
○	The amount is determined using the following formula:		
○	Other (specify):		
○	Not applicable *(see instructions)*		

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

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

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

○	Not applicable *(see instructions) Note: If the State protects the maximum amount for the waiver participant, not applicable must be checked.*
○	The State does not establish reasonable limits.
○	The State establishes the following reasonable limits *(specify)*:

c-1. Regular Post-Eligibility: 209(b) State. The State uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR §435.735. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant's income:

i. <u>Allowance for the needs of the waiver participant</u> (*select one*):				
○	The following standard included under the State plan *(select one)*			
	○	The following standard under 42 CFR §435.121:		
	○	Optional State supplement standard		
	○	Medically needy income standard		
	○	The special income level for institutionalized persons *(select one)*		
		○	300% of the SSI Federal Benefit Rate (FBR)	
		○	%	of the FBR, which is less than 300%
		○	$	which is less than 300% of the FBR
	○	%	of the Federal poverty level	
	○	Other standard included under the State Plan (specify):		
○	The following dollar amount:	$	If this amount changes, this item will be revised.	
○	The following formula is used to determine the needs allowance:			
○	Other (specify)			
ii. <u>Allowance for the spouse only</u> (*select one*):				
○	The following standard under 42 CFR §435.121			
○	Optional State supplement standard			
○	Medically needy income standard			
○	The following dollar amount:	$	If this amount changes, this item will be revised.	
○	The amount is determined using the following formula:			
○	Not applicable *(see instructions)*			
iii. <u>Allowance for the family</u> *(select one)*				

○	AFDC need standard
○	Medically needy income standard
○	The following dollar amount: $ The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
○	The amount is determined using the following formula:
○	Other (specify):
○	Not applicable *(see instructions)*

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.735:

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

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

○	Not applicable *(see instructions) Note: If the State protects the maximum amount for the waiver participant, not applicable must be checked.*
○	The State does not establish reasonable limits.
○	The State establishes the following reasonable limits *(specify)*:

NOTE: Items B-5-b-2 and B-5-c-2 are for use by states that use spousal impoverishment eligibility rules *and* elect to apply the spousal post eligibility rules.

b-2. Regular Post-Eligibility Treatment of Income: SSI State and §1634 state. The State uses the post-eligibility rules at 42 CFR §435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. <u>Allowance for the needs of the waiver participant</u> (*select one*):				
✓	The following standard included under the State plan *(select one)*			
	○	SSI standard		
	○	Optional State supplement standard		
	○	Medically needy income standard		
	✓	The special income level for institutionalized persons *(select one):*		
		✓	300% of the SSI Federal Benefit Rate (FBR)	
		○	%	of the FBR, which is less than 300%
		○	$	which is less than 300%.
	○	%	of the Federal poverty level	
	○	Other standard included under the State Plan (specify):		
○	The following dollar amount:	$	If this amount changes, this item will be revised.	
○	The following formula is used to determine the needs allowance:			
○	Other (specify):			
ii. <u>Allowance for the spouse only</u> (*select one*):				
○	The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:			
	Specify the amount of the allowance:			
	○	SSI standard		
	○	Optional State supplement standard		
	○	Medically needy income standard		
	○	The following dollar amount:	$	If this amount changes, this item will be revised.
	○	The amount is determined using the following formula:		

✓	Not applicable *(see instructions)*

iii. <u>Allowance for the family</u> *(select one)*:	
✓	AFDC need standard
○	Medically needy income standard
○	The following dollar amount: $ The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
○	The amount is determined using the following formula:
○	Other *(specify)*:
○	Not applicable *(see instructions)*

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:	
a. Health insurance premiums, deductibles and co-insurance charges b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. *Select one:*	
○	Not applicable *(see instructions) Note: If the State protects the maximum amount for the waiver participant, not applicable must be checked.*
○	The State does not establish reasonable limits.
✓	The State establishes the following reasonable limits *(specify)*:
	State Plan: Supplement 3 to attachment 2.6-A

c-2. Regular Post-Eligibility: 209(b) State. The State uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR §435.735 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant's income:

i. <u>Allowance for the needs of the waiver participant</u> (*select one*):		
○	The following standard included under the State plan *(select one)*	
	○	The following standard under 42 CFR §435.121:
	○	Optional State supplement standard
	○	Medically needy income standard
	○	The special income level for institutionalized persons *(select one)*

	○	300% of the SSI Federal Benefit Rate (FBR)	
	○	%	of the FBR, which is less than 300%
	○	$	which is less than 300% of the FBR
○	%	of the Federal poverty level	
○	Other standard included under the State Plan (specify):		
○	The following dollar amount:	$	If this amount changes, this item will be revised.
○	The following formula is used to determine the needs allowance:		
○	Other (*specify):*		

ii. <u>Allowance for the spouse only</u> (*select one*):

○	The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:		
	Specify the amount of the allowance:		
	○	The following standard under 42 CFR §435.121:	
	○	Optional State supplement standard	
	○	Medically needy income standard	
	○	The following dollar amount:	$ If this amount changes, this item will be revised.
	○	The amount is determined using the following formula:	
○	Not applicable *(see instructions)*		

iii. <u>Allowance for the family</u> *(select one)*

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

○	Other (specify):
○	Not applicable *(see instructions)*

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR 435.735:

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

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

○	Not applicable *(see instructions) Note: If the State protects the maximum amount for the waiver participant, not applicable must be checked.*
○	The State does not establish reasonable limits.
○	The State establishes the following reasonable limits *(specify)*:

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

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

i. Allowance for the personal needs of the waiver participant *(select one)*:			
○	SSI Standard		
○	Optional State Supplement standard		
○	Medically Needy Income Standard		
✓	The special income level for institutionalized persons		
○	%	of the Federal Poverty Level	
○	The following dollar amount:	$	If this amount changes, this item will be revised
○	The following formula is used to determine the needs allowance:		
○	Other (*specify*):		
ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community. *Select one:*			
✓	Allowance is the same		
○	Allowance is different. Explanation of difference:		
iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified section 1902(r)(1) of the Act:			
a. Health insurance premiums, deductibles and co-insurance charges. b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. *Select one:*			
○	Not applicable *(see instructions) Note: If the State protects the maximum amount for the waiver participant, not applicable must be checked.*		
○	The State does not establish reasonable limits.		
✓	The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.		

Appendix B-6: Evaluation/Reevaluation of Level of Care

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

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

i.	**Minimum number of services**. The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is *(insert number):* 1	
ii.	**Frequency of services**. The State requires *(select one)*:	
	✓	The provision of waiver services at least monthly
	○	Monthly monitoring of the individual when services are furnished on a less than monthly basis. If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

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

○	Directly by the Medicaid agency
○	By the operating agency specified in Appendix A
○	By an entity under contract with the Medicaid agency. *Specify the entity*:
✓	Other (*specify*):

The initial ICF/MR level of care evaluation is performed by the operating agency's Consumer Assessment Team (CAT). Reevaluations are done by service coordinators and early interventionists employed by contracted providers of the operating agency, or the CAT as needed. Internal policy dictates when this is necessary.

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

The Director of the Consumer Assessment: Minimum qualifications are a Doctorate in Applied Psychology from a designated program in Psychology; or 60 semester hours post-graduate credit towards a Doctorate in Applied Psych & 3 years experience in the practice of Applied Psych subsequent to 1 year graduate work (30) hours in Psych; or Master's degree in Applied Psych and 5

years experience in practice subsequent to Master's degree; or possession of current licensure to practice Psychology in South Carolina.

Psychologist: Minimum qualifications are a Master's degree in psychology and 4 years of clinical experience subsequent to Master's degree or possession of a license to practice psychology in the State of South Carolina. If the years of experience are not met, the psychologist will receive direct supervision and all work is reviewed by a psychologist.

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

The South Carolina level of care criteria for Intermediate Care Facitlity/Mentally Retarded issued by DHHS states:

Eligibility for Medicaid sponsored Intermediate Care Facility-Mentally Retarded (ICF/MR) in South Carolina consists of meeting the following criteria:

1. The person has a confirmed diagnosis of mental retardation, OR related disability as defined by 42 CFR 435.1009 (as amended by 42 CFR 435.1010), and South Carolina Code Section 44-20-30.

"Mental retardation" means significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period.

"Related disability" is a severe, chronic condition found to be closely related to mental retardation and must meet the four following conditions:

- It is attributable to cerebral palsy, epilepsy, autism or any other condition other than mental illness found to be closely related to mental retardation because this condition results in impairment similar to that of persons with mental retardation and requires treatment or services similar to those required for these persons.
- It is manifested before twenty-two years of age.
- It is likely to continue indefinitely.
- It results in substantial functional limitations in three or more of the following areas of major life activity: self-care, understanding and use of language, learning, mobility, self-direction and capacity for independent living.

AND

2. The person's needs are such that supervision is necessary due to impaired judgment, limited capabilities, behavior problems, abusiveness, assaultiveness or because of drug effect/medical monitorship.

AND

3. The person is in need of services directed toward a) the acquisition of the behaviors necessary to

function with as much self-determination and independence as possible; or b) the prevention or deceleration of regression of loss of current optimal functional status.

The above criteria are applied as a part of a comprehensive review conducted by an interdisciplinary team. The criteria describe the minimum services and functional deficits necessary to qualify for Medicaid sponsored ICF/MR.

Because no set of criteria can adequately describe all the possible circumstances, knowledge of an individual's particular situation is essential in applying these criteria. Professional judgment is used in rating the individual's abilities and needs.

A standardized instrument is used to gather necessary information for level of care determinations.

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

✓	The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.
○	A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan. Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

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

Evaluation: a service coordinator collects documents/information regarding the applicant's condition, need for supervision, and need for services. The gathered information is reviewed by the operating agency's Consumer Assessment Team who determines if level of care criteria is met.

Reevaluation: information regarding the participant's current condition, need for supervision, and need for services is reviewed by the participant's service coordinator (or the CAT as needed), and a determination is made. Internal policy dictates when this is necessary.

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

○	Every three months
○	Every six months
○	Every twelve months
✓	Other schedule (*specify*):
	At least every 364 days from the date of the previous LOC determination.

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

○	The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.
✓	The qualifications are different. The qualifications of individuals who perform reevaluations are *(specify)*:
	Service coordinators and early interventionists must hold a Master's or Bachelor's degree in social work or a related field or a Bachelors degree in an unrelated field of study and have one (1) year of experience working with individuals with mental retardation and related disabilities or in a case management program.

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

An automated tickler system produced by the operating agency tracks due dates and timing of reevaluations. Furthermore, reports are generated to local provider 30 days prior to expiration. Additionally, if any level of care is found out of date, FFP is recouped from the operating agency for any services that were billed when the level of care was not timely.

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

Original documents are housed with the contracted providers of the operating agency.

Quality Improvement: Level of Care

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

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

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

For each performance measure/indicator the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or

inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:	*Proportion of new enrollees whose Level of Care completion date is not within 30 days of waiver enrollment.*		
Data Source [e.g. – examples cited in IPG]]	**Responsible Party for data collection/generation** *(check each that applies)*	**Frequency of data collection/generation:** *(check each that applies)*	**Sampling Approach** *(check each that applies)*
DDSN Waiver Tracking System	☐ *State Medicaid Agency*	☐ *Weekly*	✓ *100% Review*
	✓ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☐ *Other: Specify:*	☐ *Annually*	
		✓ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	
			☐ *Other: Describe*
Data Aggregation and Analysis	**Responsible Party for data aggregation and analysis** *(check each that applies*	**Frequency of data aggregation and analysis:** *(check each that applies*	
	☐ *State Medicaid Agency*	☐ *Weekly*	
	✓ *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	✓ *Annually*	
		☐ *Continuously and Ongoing*	
		☐ *Other: Specify:*	

Add another Data Source for this performance measure

Data Source [e.g. – examples cited in IPG]]	**Responsible Party for data collection/generation** *(check each that applies)*	**Frequency of data collection/generation:** *(check each that applies)*	**Sampling Approach** *(check each that applies)*
DHHS Enrollment	✓ *State Medicaid*	☐ *Weekly*	✓ *100% Review*

Reviews	*Agency*		
	☐ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☐ *Other: Specify:*	☐ *Annually*	
		✓ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	
			☐ *Other: Describe*
Data Aggregation and Analysis	***Responsible Party for data aggregation and analysis*** *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*	
	✓ *State Medicaid Agency*	☐ *Weekly*	
	☐ *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	✓ *Annually*	
		☐ *Continuously and Ongoing*	
		☐ *Other: Specify:*	

Add another Performance measure (button to prompt another performance measure)

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

For each performance measure/indicator the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

Performance Measure:	*Proportion of participants whose Level of Care reevaluation does not occur prior to the 365th day of the previous Level of Care evaluation.*		
Data Source [e.g. – examples	***Responsible Party for data***	***Frequency of data collection/generation:***	***Sampling Approach*** *(check each that*

cited in IPG]]	***collection/generation*** *(check each that applies)*	*(check each that applies)*	*applies)*
Waiver Tracking System;	☐ *State Medicaid Agency*	☐ *Weekly*	✓ *100% Review*
	✓ *Operating Agency*	☐ *Monthly*	*Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	*Representative Sample; Confidence Interval*
	Other: Specify:	☐ *Annually*	
		✓ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	
			☐ *Other: Describe*
Data Aggregation and Analysis	***Responsible Party for data aggregation and analysis*** *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*	
	☐ *State Medicaid Agency*	☐ *Weekly*	
	✓ *Operating Agency*	*Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	
	Other: Specify:	☐ *Annually*	
		✓ *Continuously and Ongoing*	
		☐ *Other: Specify:*	

Add another Data Source for this performance measure

Data Source [e.g. – examples cited in IPG]]	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
DDSN QIO Report	☐ *State Medicaid Agency*	☐ *Weekly*	*100% Review*
	✓ *Operating Agency*	☐ *Monthly*	✓ *Less than 100% Review*
	✓ *Sub-State Entity Delmarva*	☐ *Quarterly*	✓ *Representative Sample; Confidence Interval*

	Other: Specify:	✓ *Annually*	*+/- 15%*
		☐*Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	
			☐ *Other: Describe*
Data Aggregation and Analysis	***Responsible Party for data aggregation and analysis*** *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*	
	☐ *State Medicaid Agency*	☐ *Weekly*	
	✓ *Operating Agency*	✓ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	
	Other: Specify:	☐ *Annually*	
		Continuously and Ongoing	
		☐ *Other: Specify:*	

Add another Data Source for this performance measure

Data Source [e.g. – examples cited in IPG]]	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
DHHS Record Reviews	✓ *State Medicaid Agency*	☐ *Weekly*	☐ *Review*
	☐*Operating Agency*	☐ *Monthly*	✓ *Less than 100% Review*
	☐*Sub-State Entity Delmarva*	☐ *Quarterly*	✓ *Representative Sample; Confidence Interval*
	Other: Specify:	*Annually*	*+/- 10%*
		✓ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	
			☐ *Other: Describe*
Data Aggregation and Analysis	***Responsible Party for data aggregation and analysis*** *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*	

State:	
Effective Date	

	✓ *State Medicaid Agency*	☐ *Weekly*	
	☐*Operating Agency*	☐*Monthly*	
	☐ *Sub-State Entity*	✓ *Quarterly*	
	Other: Specify:	✓ *Annually*	
		✓ *Continuously and Ongoing*	
		☐ *Other: Specify:*	

Add another Performance measure (button to prompt another performance measure)

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

For each performance measure/indicator the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

Performance Measure:	*Proportion of new enrollees whose initial Level of Care was conducted using incorrect instruments.*		
Data Source [e.g. – examples cited in IPG]]	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
DDSN QIO Record Reviews Report	*State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	✓ *Operating Agency*	*Monthly*	✓ *Less than 100% Review*
	✓ *Sub-State Entity Delmarva*	☐ *Quarterly*	✓ *Representative Sample; Confidence Interval*
	☐ *Other: Specify:*	✓ *Annually*	*+/- 15%*
		Continuously and	☐ *Stratified:*

		Ongoing	*Describe Groups*
		☐ *Other: Specify:*	
			☐ *Other: Describe*
Data Aggregation and Analysis	***Responsible Party for data aggregation and analysis*** *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*	
	☐ *State Medicaid Agency*	☐ *Weekly*	
	✓ *Operating Agency*	*Monthly*	
	✓ *Sub-State Entity Delmarva*	*Quarterly*	
	Other: Specify:	✓ *Annually*	
		Continuously and Ongoing	
		☐ *Other: Specify:*	

Add another data source

Data Source [e.g. – examples cited in IPG]]	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
DHHS QIO Record Reviews	✓ *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	Operating Agency	✓ *Monthly*	✓ *Less than 100% Review*
	✓ *Sub-State Entity*	✓ *Quarterly*	✓ *Representative Sample; Confidence Interval*
	☐ *Other: Specify:*	☐ *Annually*	*+/- 5%*
		✓ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	
			☐ *Other: Describe*
Data Aggregation	***Responsible Party for***	***Frequency of data***	

and Analysis	***data aggregation and analysis*** *(check each that applies*	***aggregation and analysis:*** *(check each that applies*	
	✓ *State Medicaid Agency*	☐ *Weekly*	
	✓ *Operating Agency*	✓ *Monthly*	
	✓ *Sub-State Entity*	✓ *Quarterly*	
	Other: Specify:	✓ *Annually*	
		☐ *Continuously and Ongoing*	
		☐ *Other: Specify:*	

Add another Performance measure (button to prompt another performance measure)

Performance Measure:	*Proportion of participants whose Level of Care outcome was appropriately determined.*		
Data Source [e.g. – examples cited in IPG]]	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
Record Reviews, off-site	✓ *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	☐ *Operating Agency*	✓ *Monthly*	✓ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	✓ *Representative Sample; Confidence Interval =*
	☐ *Other: Specify:*	☐ *Annually*	*+/- 5%*
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	
			☐ *Other: Describe*
Data Aggregation and Analysis	***Responsible Party for data aggregation and analysis*** *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*	
	✓ *State Medicaid Agency*	☐ *Weekly*	

	☐ *Operating Agency*	✓ *Monthly*	
	✓ *Sub-State Entity*	✓ *Quarterly*	
	☐ *Other: Specify:*	☐*Annually*	
		☐*Continuously and Ongoing*	
		☐ *Other: Specify:*	

Add another Data Source for this performance measure

Add another Performance measure (button to prompt another performance measure)

Performance Measure:	*Proportion of participants whose initial and/or subsequent Level of Care evaluation was denied appropriately.*		
Data Source [e.g. – examples cited in IPG]]	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
Record Reviews, off-site	✓ *State Medicaid Agency*	☐ *Weekly*	✓ *100% Review*
	Operating Agency	✓ *Monthly*	*Less than 100% Review*
	✓ *Sub-State Entity*	✓ *Quarterly*	*Representative Sample; Confidence Interval =*
	☐ *Other: Specify:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	
			☐ *Other: Describe*
Data Aggregation and Analysis	***Responsible Party for data aggregation and analysis*** *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*	
	✓ *State Medicaid Agency*	☐ *Weekly*	
	☐ *Operating Agency*	✓ *Monthly*	
	☐ *Sub-State Entity*	✓ *Quarterly*	
	☐ *Other: Specify:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	
		☐ *Other: Specify:*	

Add another Performance measure (button to prompt another performance measure)

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

Case management supervisors are required to review at least 2 case management files per case manager per month. The process includes a review of whether the case manager has sufficiently reassessed participants to conduct LOC re-evaluations, including the appropriateness, timeliness, and completeness of the LOC re-evaluation instrument and process in general, to ensure all participants are fairly and equally assessed.

b. Methods for Remediation/Fixing Individual Problems

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

DDSN Operations staff will address waiver problems when discovered. A log of participant specific problems and dates of corrective actions will be maintained and provided to the administrative agency at least quarterly.

b.ii Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)	***Responsible Party*** *(check each that applies)*	***Frequency of data aggregation and analysis:*** *(check each that applies)*
	✓ *State Medicaid Agency*	☐ *Weekly*
	✓ *Operating Agency*	☐ *Monthly*
	✓ *Sub-State Entity*	✓ *Quarterly*
	☐ *Other: Specify:*	✓ *Annually*
		✓ *Continuously and Ongoing*
		☐ *Other: Specify:*

c. Timelines

State:	
Effective Date	

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

○	**Yes** *(complete remainder of item)*
✓	**No**

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

Appendix B-7: Freedom of Choice

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

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

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

Long-term care options are discussed with potentially eligible individuals (or their legal representatives) during the assessment and subsequent visits.

A written Freedom of Choice Form is secured from each waiver participant to ensure that the participant is involved in planning his/her long-term care. This choice will remain in effect until such times as the participant changes his/her mind. If the participant lacks the physical or mental ability required to make a written choice regarding his/her care, a responsible party may sign the Freedom of Choice Form. If the Freedom of Choice Form is signed prior to the waiver participant reaching the age of eighteen, the current form or a new form is signed within 90 days after the waiver recipient reaches the age of eighteen.

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

The Freedom of Choice Form is maintained in the participant's record.

Appendix B-8: Access to Services by Limited English Proficient Persons

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

The operating agency requires that each provider agency be in compliance with Title VI and establish a grievance procedure to assure that everyone is given a fair and timely review of all complaints alleging discrimination. All contracts through the operating agency with provider agencies will contain an "Assurance of Compliance" statement. Compliance coordinators within the provider agencies will be responsible for assuring compliance and access to services by persons with limited English proficiency. The compliance coordinator is responsible for maintaining records documenting the complaints filed and actions that are taken to bring resolution to the complaint(s). A state compliance coordinator will be responsible for monitoring the compliance process. The state coordinator will assist the provider agency compliance coordinator with identifying resources when necessary. The state compliance coordinator will notify the administrative agency of any discrimination complaints that have been filed.

Appendix C: Participant Services

Appendix C-1: Summary of Services Covered

a. Waiver Services Summary. Appendix C-3 sets forth the specifications for each service that is offered under this waiver. *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

Statutory Services *(check each that applies)*		
Service	Included	Alternate Service Title (if any)
Case Management	☐	
Homemaker	☐	
Home Health Aide	☐	
Personal Care	✓	Personal Care Services
Adult Day Health	✓	Adult Day Health Care, Adult Day Health Care Services
Habilitation	☐	
Residential Habilitation	☐	
Day Habilitation	☐	
Expanded Habilitation Services as provided in 42 CFR §440.180(c):		
Prevocational Services	☐	
Supported Employment	☐	
Education	☐	
Respite	✓	Respite Care; Respite Care Services
Day Treatment	☐	
Partial Hospitalization	☐	
Psychosocial Rehabilitation	☐	
Clinic Services	☐	
Live-in Caregiver (42 CFR §441.303(f)(8))	☐	

Other Services *(select one)*	
○	Not applicable
✓	As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional services not specified in statute *(list each service by title)*:

a.	Environmental modifications
b.	Specialized medical equipment, supplies, assistive technology and appliances
c.	Psychological Services
d.	Private vehicle modifications
e.	Behavior Support Services
f.	Day Activity (a.k.a. Day Activity Services)
g.	Career Preparation (a.k.a. Career Preparation Services)
h.	Community Services
i.	Employment Services
j.	Support Center (a.k.a. Support Center Services)
k.	In-Home Support (a.k.a. In-Home Support Services)
l.	Adult Day Health Care – Nursing (a.k.a. Adult Day Health Care – Nursing Services)
m.	Adult Day Health Care – Transportation (a.k.a. Adult Day Health Care – Transportation Services)

Extended State Plan Services *(select one)*

✓	Not applicable
	The following extended State plan services are provided *(list each extended State plan service by service title)*:
a.	
b.	
c.	

Supports for Participant Direction *(check each that applies))*

☐	The waiver provides for participant direction of services as specified in Appendix E. The waiver includes Information and Assistance in Support of Participant Direction, Financial Management Services or other supports for participant direction as waiver services.
✓	The waiver provides for participant direction of services as specified in Appendix E. Some or all of the supports for participant direction are provided as administrative activities and are described in Appendix E.
○	Not applicable

Support	Included	Alternate Service Title (if any)
Information and Assistance in Support of Participant Direction	☐	
Financial Management Services	☐	

Other Supports for Participant Direction *(list each support by service title)*:

a.	

b.	
c.	

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants *(check each that applies)*:

	As a waiver service defined in Appendix C-3 (*do not complete C-1-c)*
☐	As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option). *Complete item C-1-c.*
✓	As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management). *Complete item C-1-c.*
☐	As an administrative activity. *Complete item C-1-c. NOTE: Pursuant to CMS-2237-IFC* this selection is no longer available for 1915(c) waivers.
☐	Not applicable – Case management is not furnished as a distinct activity to waiver participants. *Do not complete Item C-1-c.*

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

Service coordination functions are conducted by entities that are established by the SC Code of Laws as county DSN Boards and by entities qualified by DDSN as a service coordination provider.

Appendix C-2: General Service Specifications

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

✓	**Yes**. Criminal history and/or background investigations are required. Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):
	All service providers in this waiver are required to have background checks completed for direct care staff. These are state level checks done by the State Law Enforcement Division. Personnel information at each provider will reflect that mandatory investigations have been conducted.
○	**No**. Criminal history and/or background investigations are not required.

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

✓	**Yes**. The State maintains an abuse registry and requires the screening of individuals through this registry. Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):
	The registry captures persons convicted of abusing children under the age of 18. It is maintained by the SC Department of Social Services.
○	**No**. The State does not conduct abuse registry screening.

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

✓	**No**. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act. *Do not complete Items C-2-c.i – c.iii.*
	Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable). *Complete Items C-2-c.i –c.iii.*

i. Types of Facilities Subject to §1616(e). Complete the following table for *each type* of facility subject to §1616(e) of the Act:

Type of Facility	Waiver Service(s) Provided in Facility	Facility Capacity Limit

ii. **Larger Facilities**: In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

iii. **Scope of Facility Standards**. By type of facility listed in Item C-2-c-i, specify whether the State's standards address the following *(check each that applies)*:

Standard	Facility Type	Facility Type	Facility Type	Facility Type
Admission policies		☐	☐	☐
Physical environment		☐	☐	☐
Sanitation		☐	☐	☐
Safety		☐	☐	☐
Staff : resident ratios		☐	☐	☐
Staff training and qualifications		☐	☐	☐
Staff supervision		☐	☐	☐
Resident rights		☐	☐	☐
Medication administration		☐	☐	☐
Use of restrictive interventions		☐	☐	☐
Incident reporting		☐	☐	☐
Provision of or arrangement for necessary health services		☐	☐	☐

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

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

✓	**No**. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.
○	**Yes**. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services. Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

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

○	The State does not make payment to relatives/legal guardians for furnishing waiver services.
○	The State makes payment to relatives/legal guardians under ***specific circumstances*** and only when the relative/guardian is qualified to furnish services. Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-3 each waiver service for which payment may be made to relatives/legal guardians.*
○	Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-3. Specify any limitations on the types of relatives/legal guardians who may furnish services. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-3 each waiver service for which payment may be made to relatives/legal guardians.*
✓	Other policy. *Specify*:

	Reimbursement for services may be made to certain family members who meet SC Medicaid provider qualifications. The following family members may not be reimbursed: 1. A parent of a minor Medicaid participant; 2. A step-parent of a minor Medicaid participant; 3. A foster parent of a minor Medicaid participant; and, 4. Any other legally responsible guardian of a minor Medicaid participant or court appointed guardian of an adult Medicaid participant. 5. The spouse of a Medicaid participant. Additionally, the following family members may not be reimbursed for providing Respite: 1. Parent or step-parent of an adult Medicaid participant who resides in the same household as the respite recipient. All other qualified family members may be reimbursed for their provision of the services listed above. Should there be any question as to whether a paid caregiver falls in any of the categories listed above, DHHS legal counsel will make a determination.

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

Potential providers are given the opportunity to enroll/contract with South Carolina Medicaid and/or subcontract with DDSN. Potential providers are made aware of the requirements for enrollment through either the operating or administrating agency by contacting them directly. All potential providers are given a packet of information upon contacting the agencies that describe the requirements for enrollment, the procedures used to qualify and the timeframes established for qualifying and enrolling providers. Additionally, potential providers can find information regarding enrollment requirements and timeframes for enrollment at the state's website at: http://www.dhhs.state.sc.us/dhhsnew/insidedhhs/bureaus/BureauofLongTermCareServices/, and at the operating agency's website of **http://www.state.sc.us/ddsn/qpl/HowToBecomeQualified.htm** .

DDSN will validate that all standards and qualifications are met for any providers they initially assessed for provider qualifications to render waiver services, ensuring appropriate compliance. DDSN's QIO will conduct annual QA reviews of the waiver providers to ensure the providers continue to meet all standards and qualifications, and provide to DHHS.

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: **Qualified Providers**

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

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

Performance Measure:	*Proportion of providers that meet required licensing, certification, and other state standards prior to provision of Waiver services by provider type.*		
State Procurement Records	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☐ *State Medicaid Agency*	☐ *Weekly*	✓ *100% Review*
	✓ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	✓ *Other: Specify:*	☐ *Annually*	
	SC Budget and Control Board, Materials Management Office	✓ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	
			☐ *Other: Describe*

Add another Data Source for this performance measure

Data Source DDSN Licensing/Certification Reviews	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☐ *State Medicaid Agency*	☐ *Weekly*	✓ *100% Review*
	✓ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*

	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☐ *Other: Specify:*	✓ *Annually*	
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	
			☐ *Other: Describe*

Add another Data Source for this performance measure

Data Source DHEC Licensing/Certification Reviews	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☐ *State Medicaid Agency*	☐ *Weekly*	✓ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	✓ *Other: Specify:*	✓ *Annually*	
	SC Department of Health and Environment Control	☐ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	
			☐ *Other: Describe*

Data Source DHHS Provider Compliance Reviews	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☐ *State Medicaid Agency*	☐ *Weekly*	✓ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	✓ *Other: Specify:*	✓ *Annually*	

	SC Department of Health and Human Services	*☐ Continuously and Ongoing*	*☐ Stratified: Describe Groups*
		☐ Other: Specify:	
			☐ Other: Describe
Data Aggregation and Analysis	***Responsible Party for data aggregation and analysis*** *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*	
	✓ State Medicaid Agency	*☐ Weekly*	
	✓ Operating Agency	*☐ Monthly*	
	✓ Sub-State Entity	*✓ Quarterly*	
	☐ Other: Specify:	*✓ Annually*	
		✓ Continuously and Ongoing	
		Other: Specify:	

Add another Performance measure (button to prompt another performance measure)

Performance Measure:	*Proportion of Waiver providers that continue to meet required licensing, certification, and other state standards*		
DDSN Licensing and Certification Reviews	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☐State Medicaid Agency	*☐ Weekly*	*✓ 100% Review*
	✓ Operating Agency	*☐ Monthly*	*☐Less than 100% Review*
	☐ Sub-State Entity	*☐ Quarterly*	*☐ Representative Sample; Confidence Interval =*
	☐ Other: Specify:	*✓ Annually*	
		☐Continuously and Ongoing	*☐ Stratified: Describe Groups*
		☐ Other: Specify:	
			☐ Other: Describe

Data Source DHEC Licensing and Certification	***Responsible Party for data collection/generation***	***Frequency of data collection/generation:*** *(check each that*	***Sampling Approach*** *(check each that applies)*

Reviews	*(check each that applies)*	*applies)*	
	☐ *State Medicaid Agency*	☐ *Weekly*	✓ *100% Review*
	Operating Agency	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	✓ *Other: Specify:*	☐ *Annually*	
	SC Department of Health and Environmental Control	✓ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	
			☐ *Other: Describe*

Data Source DHHS Record Reviews	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	✓ *State Medicaid Agency*	☐ *Weekly*	*100% Review*
	Operating Agency	☐ *Monthly*	✓ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	✓ *Representative Sample; Confidence Interval =*
	☐*Other: Specify:*	☐ *Annually*	*10%*
		✓ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	
			☐ *Other: Describe*
Data Aggregation and Analysis	***Responsible Party for data aggregation and analysis*** *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*	
	✓ *State Medicaid Agency*	☐ *Weekly*	
	✓ *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	✓ *Quarterly*	
	☐ *Other: Specify:*	✓ *Annually*	

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

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

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

Performance Measure:	*Proportion of non-licensed/non-certified providers that meet Waiver requirements.*		
Data Source DHHS Review Reports	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	✓ *State Medicaid Agency*	☐ *Weekly*	*100% Review*
	☐ *Operating Agency*	☐ *Monthly*	✓ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	✓ *Representative Sample; Confidence Interval =*
	☐ *Other: Specify:*	☐ *Annually*	*10%*
		✓ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	
			☐ *Other: Describe*

Add another Data Source for this performance measure

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

	☐ *State Medicaid Agency*	☐ *Weekly*	✓ *100% Review*
	✓ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☐*Other: Specify:*	✓ *Annually*	
		☐*Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	
			☐ *Other: Describe*
Data Aggregation and Analysis	***Responsible Party for data aggregation and analysis*** *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*	
	✓ *State Medicaid Agency*	☐ *Weekly*	
	✓ *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	✓ *Annually*	
		✓ *Continuously and Ongoing*	
		☐ *Other: Specify:*	

Add another Performance measure (button to prompt another performance measure)

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

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

Performance Measure:	*Portion of providers that meet training requirements in the Waiver.*		
Data Source DDSN QIO Reviews	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☐ *State Medicaid Agency*	☐ *Weekly*	✓ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	✓ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☐ *Other: Specify:*	✓ *Annually*	
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	
			☐ *Other: Describe*

Add another Data Source for this performance measure

Data Source DHHS Provider Compliance Reviews	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	✓ *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	✓ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☐ *Other: Specify:*	✓ *Annually*	
		✓ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	
			✓ *Other: Describe*
			100% within 18 months
Data Aggregation and Analysis	***Responsible Party for data aggregation and analysis*** *(check each that*	***Frequency of data aggregation and analysis:*** *(check each that*	

	applies	applies	
	✓ *State Medicaid Agency*	☐ *Weekly*	
	✓ *Operating Agency*	☐ *Monthly*	
	✓ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	✓ *Annually*	
		✓ *Continuously and Ongoing*	
		☐ *Other: Specify:*	

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

b. Methods for Remediation/Fixing Individual Problems

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

a. A list of agencies applying to provide waiver services, reasons for denial, and steps that should be taken to reapply will be maintained.
b. Lists of agencies that were reviewed, compliance issues uncovered, and corrections made will be maintained along with correction and timeframes of correction.

DDSN will provide both lists to the administering agency on a quarterly basis.

b.ii Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)	***Responsible Party*** *(check each that applies)*	***Frequency of data aggregation and analysis:*** *(check each that applies)*
	✓ *State Medicaid Agency*	☐ *Weekly*
	✓ *Operating Agency*	☐ *Monthly*
	✓ *Sub-State Entity* Delmarva	☐ *Quarterly*

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

c. Timelines

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

○	**Yes** *(complete remainder of item)*
✓	**No**

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

Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification	
Service Title:	Personal Care Services
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
○	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
	Service is not included in the approved waiver.
Service Definition (Scope)**:**	
Assistance, either hands-on (actually performing a personal care task for a person) or cuing so that the person performs the task by him/herself, in the performance of IADLs or ADLs. ADLs include eating,, bathing, dressing, toileting, transferring, and maintaining continence. IADLs capture more complex life-like activities and include personal hygiene, light housework, laundry, meal preparation, transportation, grocery shopping, using the telephone, medication management, to include informing a client that it is time to take medication as prescribed by his/her physician or handing a client a medication container, and money management to consist on delivering payments to a designated recipient of behalf of the client. Personal care services can be provided on a continuing basis or on episodic occasions. Skilled services that may be performed only by a health	

professional are not considered personal care services, to the extent allowed under state law. Authorization of this service will be made to providers at two different payment levels. The higher level will be called Personal Care 2 and will be used when the majority of care is related to activities of daily living. The lower level, Personal Care 1, will be authorized when most of the needed care is for instrumental activities of daily living.

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

Provider Specifications

Provider Category(s) *(check one or both)*:	☐	Individual. List types:	✓	Agency. List the types of agencies:

Specify whether the service may be provided by *(check each that applies)*:	☐	Legally Responsible Person	✓	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Personal Care Provider	DHHS		Contract Scope of Services
Personal Care Provider	DHHS		

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Personal Care Provider	DHHS	Upon enrollment; at least every 18 months

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	✓	Provider managed

Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification	
Service Title:	ADULT DAY HEALTH CARE
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
○	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.
Service Definition (Scope)**:**	
Services furnished 4 or more hours per day on a regularly scheduled basis, for one or more days per week, in an outpatient setting, encompassing both health and social services needed to ensure the optimal functioning of the individual. Authorization of services will be based on the recipient's need for the service as identified and documented in the individual's plan of care. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day). Physical, occupational and speech therapies indicated in the individual's plan of care are not furnished as component parts of this service.	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	✓	Agency. List the types of agencies:
				Adult Day Health Care Provider
Specify whether the service may be provided by *(check each that applies)*:	☐	Legally Responsible Person	✓	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Adult Day Health Care Provider	SC Code Annotated §44-7-260 (Supp. 2007); 25 SC Code Annual Regulations 61-75 (1976)		Contract Scope of Service

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Adult Day Health Care Provider	Department of Health and Environmental Control; DHHS	Upon Enrollment; at least every 18 months

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	✓	Provider managed

Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification	
Service Title:	Respite
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
○	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Care and supervision provided to those individuals unable to care for themselves. Services are provided due to the short-term absence or need of relief of those normally providing care. Respite is provided in a variety of settings and may be provided on an hourly or daily basis. FFP will not be claimed for the cost of room and board except when provided as part Respite provided in a facility approved by the State that is not a private residence.

Respite may be provided in the following locations:

Individual's home or other private residence selected by the participant/representative;
Group home;
Foster home;
Medicaid certified nursing facility;
Medicaid certified ICF/MR; and/or,
Licensed Community Residential Care facility.

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

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	✓	Agency. List the types of agencies:
				Licensed Community Residential Care Facility
				DSN Board/Contracted provider
				SCDSS licensed Foster Home
				Medicaid certified ICF/MR
				Medicaid certified nursing facility
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	✓	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):			
Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Licensed Community Residential Care Facility	SC Code, Sec. 44-7-260 Reg. #61-84, Equivalent for NC & GA		
DSN Board/Contracted provider	SC Code Ann. §44-20-10 thru 44-20-5000 (Supp 2007); §44-20-710 (Supp 2007)		DDSN Respite Standards
SCDSS licensed Foster Home	SC Code, Sec. 20-7-2250		
Medicaid certified ICF/MR	44-7-260 Reg 61.103		
Medicaid certified nursing facility	SC Code, Sec. 44-7-250 Reg. #61-17, Equivalent for NC & GA		

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Licensed Community Residential Care Facility	Medicaid Agency, Department of Health and Environmental Control	Upon Enrollment; Annually
DSN Board/Contracted provider	Department of Disabilities and Special Needs	Upon enrollment; annually
SCDSS licensed Foster Home	Department of Social Services	Upon Enrollment; Annually
Medicaid certified ICF/MR	Department of Disabilities and Special Needs	Upon Enrollment; Annually
Medicaid certified nursing facility	Department of Health and Environmental Control	Upon Enrollment; Annually

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	✓	Provider managed

Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification	
Service Title:	ENVIRONMENTAL MODIFICATIONS
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
○	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
	Service is not included in the approved waiver.
Service Definition (Scope)**:**	
Those physical adaptations to the home, required by the individual's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence, and without which, the individual would require institutionalization. Home is defined as non-government subsidized living quarters, and modifications to any government-subsidized housing (i.e., group homes or community residential care facilities) are not permitted. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems, which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the individual. Environmental modifications may also include consultation and assessments to determine the specific needs and follow-up inspections upon completion of the project. Excluded are those adaptations or improvements to the home, which are of general utility, and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc. Adaptations that add square footage to the home are excluded from this benefit. All services shall be provided in accordance with applicable State or local building codes. Approval of a request for environmental modification is a multi-step process. The modification is initially determined by the service coordinator/early interventionist based on the recipient's need as documented in the plan of care. Three bids for the modification are obtained by the service coordinator/early interventionist and submitted with documentation of the need. The consultation/assessment does not require the submission of bids. This information is reviewed by South Carolina Department of Disabilities and Special Needs (SCDDSN) staff for programmatic integrity and cost effectiveness.	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	

Provider Specifications				
Provider Category(s) *(check one or both)***:**	✓	Individual. List types:	✓	Agency. List the types of agencies:
	Licensed contractors		Licensed contractors	
	Licensed Occupational and Physical Therapists			

	Rehabilitation Engineering Technologists, Assistive Technology Practitioners and Assistive Technology Suppliers certified by the Rehabilitation Engineering Society of North America (RESNA)	Occupational and Physical Therapy Agencies
	Environmental Access Consultants/contractors certified by Professional Resources in Management (PRIME).	Rehabilitation Engineering Technologists, Assistive Technology Practitioners and Assistive Technology Suppliers certified by the Rehabilitation Engineering Society of North America (RESNA)
	Technicians or professionals certified in the installation and repair of manufacturers equipment	Environmental Access Consultants/contractors certified by Professional Resources in Management (PRIME).
		Vendors with a retail or wholesale business license contracted to provide services
		Technicians or professionals certified in the installation and repair of manufacturers equipment

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	✓	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Licensed Contractor	SC Code Ann. §40-59-15 (Supp. 2007)		Medicaid Enrolled Providers or Contracted with Department of Disabilities and Special Needs
Licensed Physical and Occupational Therapists	SC Code Ann §40-45-5 thru 40-45-330, (Supp 207) Equivalent NC and GA SC Code Ann. §40-36-5 thru 40-36-310 (Supp 207) Equivalent NC and GA		Medicaid Enrolled Providers or Contracted with Department of Disabilities and Special Needs
Rehabilitation Engineering Technologists, Assistive Technology Practitioners and Assistive Technology		Certified by the Rehabilitation Engineering Society of North America (RESNA)	Medicaid Enrolled Providers or Contracted with Department of Disabilities and Special Needs

Suppliers			
Environmental Access Consultants/contractors		Certified by Professional Resources in Management (PRIME).	Medicaid Enrolled Providers or Contracted with Department of Disabilities and Special Needs
Technicians or professionals certified in the installation and repair of manufacturers equipment	SC Code Ann. §33-1-101 thru 33-1-420 ((Supp 2007)		Medicaid Enrolled Providers or Contracted with Department of Disabilities and Special Needs
Vendors with a retail or wholesale business license contracted to provide services	SC Code Ann. §33-1-101 thru 33-1-420 (Supp 2007)		Medicaid Enrolled Providers or Contracted with Department of Disabilities and Special Needs

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Licensed Contractor	SCDDSN and/or SCDHHS	Upon service authorization
Licensed Physical and Occupational Therapists	SCDDSN and/or SCDHHS	Upon service authorization
Rehabilitation Engineering Technologists, Assistive Technology Practitioners and Assistive Technology Suppliers	SCDDSN and/or SCDHHS	Upon service authorization
Environmental Access Consultants/contractors	SCDDSN and/or SCDHHS	Upon service authorization
Technicians or professionals certified in the installation and repair of manufacturers equipment	SCDDSN and/or SCDHHS	Upon service authorization
Vendors with a retail or wholesale business license contracted to provide services	SCDDSN and/or SCDHHS	Upon service authorization and/ or Medicaid enrollment

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	✓	Provider managed

Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification	
Service Title:	SPECIALIZED MEDICAL SUPPLIES, EQUIPMENT, ASSISTIVE TECHNOLOGY AND APPLIANCES
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
○	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
	Service is not included in the approved waiver.
Service Definition (Scope)**:**	
Specialized medical equipment, supplies, and assistive technology to include devices, controls, or appliances, specified in the plan of care, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, repairs not covered by warranty, replacement of parts or equipment, and durable and non-durable medical equipment not available under the Medicaid State plan. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State plan and shall exclude those items which are not of direct medical or remedial benefit to the individual. All items shall meet applicable standards of manufacture, design and installation. This service may include consultation and assessment to determine the specific needs related to the individual's disability for which specialized medical equipment, supplies, and assistive technology will assist the individual to function more independently. Consultation and assessment cannot be used to determine the need for supplies.	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	

Provider Specifications				
Provider Category(s) *(check one or both)***:**	✓	Individual. List types:	✓	Agency. List the types of agencies:
	Independent Rehabilitation Engineering Technologists, assistive technology practitioners, and assistive technology suppliers certified by the Rehabilitation Engineering Society of North America. (RESNA)		Durable Medical Equipment Providers	
	Independent Environmental Access Consultants/contractors certified by Professional Resources in Management (PRIME)		DSN Board/contracted providers	

	Licensed Occupational or Physical Therapists	Licensed Occupational or Physical Therapy Agencies
	Technicians or professionals certified in the installation and repair of manufacturer's equipment	Independent Rehabilitation Engineering Technologists, assistive technology practitioners, and assistive technology suppliers certified by the Rehabilitation Engineering Society of North America. (RESNA)
		Independent Environmental Access Consultants/contractors certified by Professional Resources in Management (PRIME)
		Vendors with a retail or wholesale business license
		Technicians or professionals certified in the installation and repair of manufacturer's equipment

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	✓	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Durable Medical Equipment Provider	SC Code Ann. § 33-1-200 thru 33-1-420 (Supp. 2007)		SCDDSN and/or SCDHHS contract or enrollment
DSN Board/contracted providers	SC Code Ann. §44-20-10 thru 44-10-510 (Supp 2007)		SCDDSN and/or SCDHHS contract or enrollment
Licensed Occupational or Physical Therapy Agencies	SC Code Ann. §40-45-5 thru 40-45-330 (Supp 2007) Equivalent NC and GA SC Code Ann. §40-36-5 thru 40-36-310 (Supp 2007)		SCDDSN and/or SCDHHS contract or enrollment
Independent Rehabilitation Engineering Technologists, assistive technology practitioners, and assistive technology suppliers certified by the Rehabilitation Engineering Society of North America.		Certified by the Rehabilitation Engineering Society of North America (RESNA)	SCDDSN and/or SCDHHS contract or enrollment

(RESNA)			
Independent Environmental Access Consultants/contractors certified by Professional Resources in Management (PRIME)		Certified by Professional Resources in Management (PRIME).	SCDDSN and/or SCDHHS contract or enrollment
Vendors with a retail or wholesale business license	SC Code Ann. §33-1-101 thru 33-1-420 (Supp 2007)		SCDDSN and/or SCDHHS contract or enrollment
Technicians or professionals certified in the installation and repair of manufacturer's equipment	SC Code Ann. §33-1-101 thru 33-1-420 (Supp 2007)		SCDDSN and/or SCDHHS contract or enrollment

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Durable Medical Equipment Provider	SCDDSN and/or SCDHHS	Upon Enrollment
DSN Boards/contracted providers	SCDDSN and/or SCDHHS	Annually
Licensed Physical and Occupational Therapists	SCDDSN and/or SCDHHS	Upon service authorization
Rehabilitation Engineering Technologists, Assistive Technology Practitioners and Assistive Technology Suppliers	SCDDSN and/or SCDHHS	Upon service authorization
Environmental Access Consultants/contractors	SCDDSN and/or SCDHHS	Upon service authorization
Technicians or professionals certified in the installation and repair of manufacturers equipment	SCDDSN and/or SCDHHS	Upon service authorization
Vendors with a retail or wholesale business license contracted to provide services	SCDDSN and/or SCDHHS	Upon service authorization and/ or Medicaid enrollment

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	✓	Provider managed

Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification	
Service Title:	PSYCHOLOGICAL SERVICES
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
○	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
	Service is not included in the approved waiver.
Service Definition (Scope)**:**	
Services focused upon assessment of needs and counseling/therapy designed to address specific needs in areas such as cognitive and/or affective skills. These services include initial assessment for determining need for and appropriateness of psychological services, goal-orientated counseling/therapy focused on issues related to seriously inappropriate behavior including sexual behavior (e.g., those behaviors which could lead to criminal sexual misconduct).	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	

Provider Specifications				
Provider Category(s) *(check one or both)***:**	✓	Individual. List types:	☐	Agency. List the types of agencies:
	Psychological Services Providers			

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	✓	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Psychological Services Provider			Verified by DDSN and approved by DHHS

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Psychological Services Providers	DDSN and/or DHHS	Upon Enrollment

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	✓	Provider managed

Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification	
Service Title:	PRIVATE VEHICLE MODIFICATIONS
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
○	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
	Service is not included in the approved waiver.
Service Definition (Scope)**:**	

Modifications to a privately owned vehicle used to transport the waiver recipient, and for any equipment needed by the recipient which makes the vehicle accessible to the recipient. Modification to any government-subsidized vehicle is not permitted. Private vehicle modifications may include consultation and assessment to determine the specific modifications/equipment needed follow-up inspection after modifications are completed, training in the use of equipment, repairs not covered by warrant and replacement of part or equipment. Private vehicle modifications may not be used for general repair of the vehicle.

The approval process for vehicle modifications is initially determined by the Service Coordinator or Early Interventionist based on the recipient's needs as identified and documented in the plan of care, the consultation/assessment results (if applicable), and the availability of a privately owned vehicle that would be used for transportation on a routine basis. The criterion used in assessing a recipient's need for this service are: 1) The parent or family member cannot transport the individual because the individual cannot get in or out of the vehicle; 2) The individual can drive but cannot get in or out of the vehicle and a modification to the vehicle would resolve this barrier. Bids for the service are obtained and submitted along with the documentation of the need to SCDDSN. The consultation/assessment does not require the submission of bids. Each request is reviewed programmatically and fiscally before approval is given. The approval process is the same for any privately owned vehicle modification, regardless of ownership.

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

Provider Specifications				
Provider Category(s) *(check one or both)***:**	✓	Individual. List types:	✓	Agency. List the types of agencies:
	Private Vehicle Modifications Provider		Durable Medical Equipment Providers	
			Private Vehicle Modifications Provider	

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	✓	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:			
Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Private Vehicle Modifications Provider (individual and agency)	SC Code Ann. §33-1-100 thru 33-1-420, (Supp. 2007)		Trained and certified in the installation and repair of the manufacturer's equipment.
Durable Medical Equipment Provider	SC Code Ann. § 33-1-200 thru 33-1-420 (Supp. 2007)		Trained and certified in the installation and repair of the manufacturer's equipment.

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Private Vehicle Modifications Provider	SCDDSN and/or SCDHHS	Before service authorization.
Durable Medical Equipment Provider	SCDDSN and/or SCDHHS	Before service authorization.

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	✓	Provider managed

Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification	
Service Title:	BEHAVIOR SUPPORT SERVICES
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
○	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.
Service Definition (Scope)**:**	
Services which use current empirically validated practices to identify causes of, intervene to prevent, and appropriately react to problematic behavior. These services include initial assessment for determining need for and appropriateness of behavior support services; behavioral assessment (i.e., functional assessment and/or analysis) that includes direct observation, interview of key persons, collection of objective data; analysis of behavioral/functional assessment data to determine the function of the behaviors (and later to assess success of intervention and any needed modifications) and behavioral intervention based on the functional assessment that is primarily focused on prevention of the problem behavior(s) based on their function.	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	

Provider Specifications				
Provider Category(s) *(check one or both)***:**	✓	Individual. List types:	☐	Agency. List the types of agencies:
	Behavior Support Provider			

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	✓	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Behavior Support Provider			Verified by DDSN and approved by DHHS.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Behavior Support	DDSN and/or DHHS	Upon enrollment

Provider				
Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	✓	Provider managed

Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification	
Service Title:	DAY ACTIVITY
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
○	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
	Service is not included in the approved waiver.
Service Definition (Scope)**:**	

Supports and services provided in therapeutic settings to enable participants to achieve, maintain, improve, or decelerate the loss of personal care, social or adaptive skills. Services are provided in non-residential settings that are licensed by the state. Community activities that originate from a facility licensed by the state will be provided and billed as Day Activity. On site attendance at the licensed facility is not required to receive services that originate from the facility.

Transportation will be provided from the participant's residence to the habilitation site when the service start time is before 12:00 Noon. Transportation will be available from the participant's habilitation site to their residence when the service start time is after 12:00 Noon. The cost for transportation is included in the rate paid to the provider.

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

Provider Specifications				
Provider Category(s) *(check one or both)***:**		Individual. List types:	✓	Agency. List the types of agencies:
				Day Activity Provider
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	✓	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Day Activity Provider	SC Code Annotated § 44-20-710 (Supp 2007) ; 26 SC Code Ann. Regs. 88-105 thru 88-920 (1976)		SCDDSN Standards for Day Activity Services

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Day Activity Provider	DDSN	Initially, annually

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	✓	Provider managed

Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification	
Service Title:	CAREER PREPARATION SERVICES
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
○	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
	Service is not included in the approved waiver.
Service Definition (Scope)**:**	

Services aimed at preparing participants for paid or unpaid employment and careers through exposure to and experience careers and through teaching such concepts as compliance, attendance, task completion, problem solving, safety, self determination, and self-advocacy. Services are not job-task oriented, but instead aimed at a generalized result. Services are reflected in the participant's service plan and are directed to habilitative rather than explicit employment objectives. Services will be provided in facilities licensed by the state. Community activities that originate from a facility licensed by the state will be provided and billed as Career Preparation. On site attendance at the licensed facility is not required to receive services that originate from the facility.

Transportation will be provided from the participant's residence to the habilitation site when the service start time is before 12:00 Noon. Transportation will be available from the participant's habilitation site to their residence when the service start time is after 12:00 Noon. The cost for transportation is included in the rate paid to the provider.

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

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	✓	Agency. List the types of agencies:
				Career Preparation Provider
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	✓	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Career Preparation Provider	SC Code Annotated § 44-20-710 (Supp 2007); 26 SC Code Ann. Regs 88-105		SCDDSN Career Preparation Standards

	thru 88-020 (1976)		

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Career Preparation Provider	DDSN	Initially and annually

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	✓	Provider managed

Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification	
Service Title:	COMMUNITY SERVICES
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
○	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
	Service is not included in the approved waiver.
Service Definition (Scope)**:**	

Services aimed at developing one's awareness of, interaction with and/or participation in their community through exposure to and experience in the community and through teaching such concepts as self-determination, self-advocacy, socialization and the accrual of social capital. Services will be provided in facilities licensed by the state. Community activities that originate from a facility licensed by the state will be provided and billed as Community Services. On site attendance at the licensed facility is not required to receive services that originate from the facility. Payment for community services may not include payment for room and board.

Transportation will be provided from the participant's residence to the habilitation site when the service start time is before 12:00 Noon. Transportation will be available from the participant's habilitation site to their residence when the service start time is after 12:00 Noon. The cost for transportation is included in the rate paid to the provider.

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

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	✓	Agency. List the types of agencies:
				Community Services Provider

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	✓	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Community Services Provider	SC Code Annotated § 44-20-710 (Supp 2007); 26 SC Code Ann. Regs. 88-105		SCDDSN Community Services Standards

	thru 88-920 (1976)		

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Community Services Provider	DDSN	Initially and annually

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	✓	Provider managed

Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification	
Service Title:	EMPLOYMENT SERVICES
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
○	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
	Service is not included in the approved waiver.
Service Definition (Scope)**:**	
Employment services consist of intensive, on-going supports that enable participants for whom competitive employment at or above minimum wage is unlikely absent the provision of supports and who, because of their disabilities, need supports to perform in a regular work setting. Employment services may include services to assist the participant to locate a job or develop a job on behalf of the participant. Employment services are conducted in a variety of settings, particularly work sites where persons without disabilities are employed and include activities such as supervision and training needed to sustain paid work. Employment services may be provided in group settings, such as mobile work crews or enclaves, or in community-based individual job placements.	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	✓	Agency. List the types of agencies:
				Employment Services Provider

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	✓	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Employment Services Provider			SCDDSN Employment Services Standards

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Employment Services Provider	DDSN	Initially and annually

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	✓	Provider managed

Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification	
Service Title:	SUPPORT CENTER SERVICES
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
○	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.
Service Definition (Scope)**:**	

Non-medical care, supervision and assistance provided in a non-institutional, group setting outside of the participant's home to people who because of their disability are unable to care for and supervise themselves. Services provided are necessary to prevent institutionalization and maintain the participants' health and safety. The care, supervision and assistance will be provided in accordance with a plan of care. An array of non - habilitative activities and opportunities for socialization will be offered throughout the day but not as therapeutic goals.

Transportation will be provided from the participant's residence to the habilitation site when the service start time is before 12:00 Noon. Transportation will be available from the participant's habilitation site to their residence when the service start time is after 12:00 Noon. The cost for transportation is included in the rate paid to the provider.

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

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	✓	Agency. List the types of agencies:
				Support Center Services Provider

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	✓	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Support Center Services Provider	SC Code Annotated § 44-20-710 (Supp 2007); 26 C Code Ann. Regs 88-105		SCDDSN Standards for Support Center Services

	thru 88-920 (1976)		

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Support Center Services Providers	DDSN	Initially and annually

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	✓	Provider managed

Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification	
Service Title:	IN-HOME SUPPORT
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
○	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
	Service is not included in the approved waiver.
Service Definition (Scope)**:**	

Care, supervision, teaching and/or assistance provided directly to or in support of the participant and provided in the participant's home, family home, the home of others, and/or in community settings. Community activities that originate from the home will be provided and billed as In Home Support. These services are necessary to enable the person to live in the community by enhancing, maintaining, improving or decelerating the rate of regression of skills necessary to continue to live in the community.

If the caregiver or participant incurs cost for vehicle operation to or from activities or other transportation costs, additional reimbursement beyond the payment of the hourly rate paid to the In Home Support provider will not be made.

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

Provider Specifications				
Provider Category(s) *(check one or both)***:**	✓	Individual. List types:	☐	Agency. List the types of agencies:
	Independent in-home support providers			

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	✓	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
In-Home Support providers			DDSN In-Home Support Standards

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
In-Home Support Provider	DDSN/Waiver participant/Representative	Upon enrollment; annually

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	✓	Participant-directed as specified in Appendix E	☐	Provider managed

Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification	
Service Title:	Adult Day Health Care - Transportation
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
○	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
	Service is not included in the approved waiver.
Service Definition (Scope)**:**	
This service is prior-authorized for participants receiving the Adult Day Health Care (ADHC) service, who reside within fifteen (15) miles of the ADHC Center. Transportation will be provided using the most direct route, door to door, from the Center to the participant's place of residence or other location, as agreed to by the provider and as indicated on the service authorization.	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	✓	Agency. List the types of agencies:
				Adult Day Health Care Agency

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	✓	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Adult Day Health Care Provider	SC Code Ann. §44-7-260, (Supp 2007); 25 SC Code Ann. Regs. 61-75 (1976)		Contracted with the DHHS agency for Adult Day Health Care transportation.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Adult Day Health Care	Department of Health and Environmental	Upon Enrollment;

Provider	Control; DHHS	At least every 18 months

Service Delivery Method				
Service Delivery Method *(check each that applies)*:		Participant-directed as specified in Appendix E	✓	

Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification	
Service Title:	Adult Day Health Care - Nursing
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
○	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
	Service is not included in the approved waiver.
Service Definition (Scope)**:**	
Nursing services provide in and by the Adult Day Health Care Center and limited to the following skilled procedures as ordered by a physician: Ostomy Care, Urinary Catheter Care; Decubitus/Wound Care; Tracheotomy Care; Nebulizer; and Tube Feedings.	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	✓	Agency. List the types of agencies:
				Adult Day Health Care Agency
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	✓	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Adult Day Health Care Provider	SC Code Ann. §44-77-260, (Supp 2007); 25 SC Code Ann. Regs. 61-75 (1976)		Enrolled and Contracted with the Medicaid agency for Adult Day Health Care nursing.

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Adult Day Health Care Provider	Department of Health and Environmental Control; DHHS	Upon Enrollment; At least every 18 months

Service Delivery Method				
Service Delivery Method *(check each that applies)*:		Participant-directed as specified in Appendix E	✓	

Appendix C-4: Additional Limits on Amount of Waiver Services

Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services *(check each that applies)*.

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

☐	**Limit(s) on Set(s) of Services**. There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver. *Furnish the information specified above*.
☐	**Prospective Individual Budget Amount**. There is a limit on the maximum dollar amount of waiver services authorized for each specific participant. *Furnish the information specified above*.
☐	**Budget Limits by Level of Support**. Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services. *Furnish the information specified above*.
☐	**Other Type of Limit.** The State employs another type of limit. *Describe the limit and furnish the information specified above.*
✓	**Not applicable.** The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

Appendix D: Participant-Centered Planning and Service Delivery

Appendix D-1: Service Plan Development

State Participant-Centered Service Plan Title:	Support Plan

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

☐	Registered nurse, licensed to practice in the State
☐	Licensed practical or vocational nurse, acting within the scope of practice under State law
☐	Licensed physician (M.D. or D.O)
☐	Case Manager (qualifications specified in Appendix C-3)
☐	Case Manager (qualifications not specified in Appendix C-3). *Specify qualifications*:
☐	Social Worker. *Specify qualifications:*
✓	Other (*specify the individuals and their qualifications):*
	Service Coordinator/Early Interventionist; must hold at least a Bachelor's degree in social work or a related field from an accredited college or university or hold a Bachelor's degree in an unrelated field from an accredited college or university and have at least one year of experience in a case management program and demonstrate knowledge of disabilities.

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

○	Entities and/or individuals that have responsibility for service plan development *may not provide* other direct waiver services to the participant.
✓	Entities and/or individuals that have responsibility for service plan development *may provide* other direct waiver services to the participant. The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify*:
	The state utilizes a standardized tool for assessing the needs of all waiver participants. Once needs are identified and prioritized, service coordinators explain the service options that are available to meet those needs. Participants are given the names of all available service providers from which they may choose. Their choice is documented.

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as

appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

During the planning process the participant, his/her legal guardian, caregivers, professional service providers (including physician) and others of the participant's choosing provide input. The information obtained is used by the case manager in order to develop the Service Plan. The participant/legal guardian will receive a copy of the Service Plan upon completion. Copies will also be provided to others of the participant's/legal guardian's choosing.

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

The Service Plan is developed by the service coordinator and is based on the comprehensive assessment of the waiver participant's strengths, needs, and personal priorities (goals) and preferences. The participant, his/her legal guardian, caregivers, professional service providers (including physician) and others of the participant's choosing may provide input. Service plans are developed prior to the delivery of a waiver-funded service and at least within 364 days of the previous service plan or more often as the participant's needs change.

Participants are informed in writing at the time of enrollment of the names and definitions of waiver services that can be funded through the waiver when the need for the service has been identified by the service coordinator. When waiver is amended, the information is again provided, as needed

Participation in the planning process by the participant, his/her guardian, knowledgeable professionals and others of the participant's choosing, helps to assure that the participant's personal priorities and preferences are recognized and addressed by the plan. The service coordinator must utilize information about the participant's strengths, priorities, and preferences to determine how prioritized needs will be addressed. The plan will include a statement of the participant's need, indication of whether or not the need relates to a personal goal, the specific service to meet the need, the amount, frequency, duration of the service, and the type of provider who will furnish the service.

The plan will include the roles and responsibilities of the service coordinator and the participant and his/her guardian for each service included in the plan. The service coordinator will have primary responsibility for coordination of services but must rely on the participant/guardian to choose a service provider from among those available, avail him/herself for, and honor appointments scheduled with providers when needed for initial service implementation, and cooperate with coordination efforts. The degree of coordination may vary based on the needs of the

participant and his/her support network and their preferences for self-coordination.

On at least a quarterly basis, there will be a review of the entire waiver plan of care to determine if updates are needed. On an annual basis, there will be a face-to-face contact with the participant/family during which the effectiveness, usefulness, and benefits of the plan will be discussed along with the participant's/family's satisfaction with the services/providers.

Changes to the plan will be made as needed by the service coordinator when the results of monitoring or when information obtained from the participant, his/her guardian, and/or service providers indicates the need for a change to the plan.

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

Participants' needs, including potential risks associated with their situations, are assessed during the annual planning process and considered during plan development. The plan includes a section for a description of the plan to be implemented during an emergency or natural disaster and a description of how care will be provided in the unexpected absence of a caregiver/supporter.

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

Upon request or as service needs change, participants are given a list of providers of all waiver services in order to select a provider. This list includes phone numbers. Participants are encouraged to phone providers with questions, ask friends about their experiences with providers and utilize other information sources in order to select a provider.

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

The format and content of the questions for the support plan document, as well as the intended planning process must be reviewed and approved by the Medicaid agency prior to implementation. Participant plans are available upon request. A sample of participant plans are reviewed by the operating agency and results shared with the service coordinator and his/her supervisor so that corrections can be made if needed. These results are also shared with DHHS. DHHS conducts validation reviews, which include a sample of participant plans.

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

○	Every three months or more frequently when necessary
○	Every six months or more frequently when necessary
○	Every twelve months or more frequently when necessary
✓	Other schedule (*specify*):
	At least every 364 days from the date of the previous Service Plan.

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

☐	Medicaid agency
☐	Operating agency
☐	Case manager
✓	Other (*specify):*
	Service Coordinator

Appendix D-2: Service Plan Implementation and Monitoring

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

At a minimum, Service Coordinators will provide quarterly contact with the participant and/or family. On a quarterly basis, there will be a review of the Support Plan which includes the most recent contact with the participant/family.

b. Monitoring Safeguards. *Select one:*

○	Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare *may not provide* other direct waiver services to the participant.
✓	Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare *may provide* other direct waiver services to the participant. The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify*:
	DDSN policy dictates the minimum frequency with which monitoring must occur and the elements (service effectiveness/usefulness, service providers, frequency and duration, and participant/family satisfaction with services) that must be included. Monitoring is documented using a standardized format that includes the noted elements along with actions to be taken when concerns are noted. As appropriate, when concerns are noted, participants/families are given information about all available service providers from which they may choose. Monitoring is reviewed by the State as part of its quality assurance/compliance process.

Quality Improvement: Service Plan

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

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

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

For each performance measure/indicator the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or

inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:	*Proportion of participants whose plans includes services and supports that are consistent with needs and personal goals identified in the comprehensive assessment.*		
Data Source DDSN QIO Reviews	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☐ *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	✓ *Less than 100% Review*
	✓ *Sub-State Entity*	☐ *Quarterly*	✓ *Representative Sample; Confidence Interval*
	☐ *Other: Specify:*	✓ *Annually*	*+/- 15%*
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	
			☐ *Other: Describe*

Add another Data Source for this performance measure

Data Source DHHS Reports	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	✓ *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	✓ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	✓ *Representative Sample; Confidence Interval =*
	☐ *Other: Specify:*	☐ *Annually*	*10%*
		✓ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	
			Other: Describe

State:	
Effective Date	

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

Add another Performance measure (button to prompt another performance measure)

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

For each performance measure/indicator the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

Performance Measure:	*Proportion of participants who received assessments in accordance with State policy.*		
Data Source DDSN QIO Reviews	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☐ *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	✓ *Operating Agency*	☐ *Monthly*	✓ *Less than 100% Review*
	✓ *Sub-State Entity*	☐ *Quarterly*	✓ *Representative Sample; Confidence Interval*

State:	
Effective Date	

	☐ *Other: Specify:*	✓ *Annually*		*=+/- 15%*
		☐*Continuously and Ongoing*		☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*		
				☐ *Other: Describe*

Add another Data Source for this performance measure

Data Source ***DHHS Review Reports***	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	✓ *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	✓ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	✓ *Representative Sample; Confidence Interval =*
	☐ *Other: Specify:*	☐ *Annually*	*10%*
		✓ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	
			☐ *Other: Describe*
Data Aggregation and Analysis	***Responsible Party for data aggregation and analysis*** *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*	
	✓ *State Medicaid Agency*	☐ *Weekly*	
	✓ *Operating Agency*	☐ *Monthly*	
	✓ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	✓ *Annually*	
		✓ *Continuously and Ongoing*	
		☐ *Other: Specify:*	

Add another Performance measure (button to prompt another performance measure)

State:	
Effective Date	

Performance Measure:	*Proportion of participants whose plans were completed in a timely fashion.*		
Data Source DDSN QIO Reports	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☐ *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	✓ *Operating Agency*	☐ *Monthly*	✓ *Less than 100% Review*
	✓ *Sub-State Entity*	☐ *Quarterly*	✓ *Representative Sample; Confidence Interval =+/-*
	☐ *Other: Specify:*	✓ *Annually*	*15%*
		☐*Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	
			☐ *Other: Describe*

Data Source DHHS Review Reports	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	✓ *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	✓ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	✓ *Representative Sample; Confidence Interval =*
	☐ *Other: Specify:*	☐ *Annually*	*10%*
		✓ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	
			☐ *Other: Describe*
Data Aggregation and Analysis	***Responsible Party for data aggregation and analysis*** *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*	

State:	
Effective Date	

	✓ *State Medicaid Agency*	☐ *Weekly*	
	✓ *Operating Agency*	☐ *Monthly*	
	✓ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	✓ *Annually*	
		✓ *Continuously and Ongoing*	
		☐ *Other: Specify:*	

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

For each performance measure/indicator the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

Performance Measure:	*Proportion of participants who received an annual re-assessment in accordance with State policy*		
Data Source DDSN QIO Reports	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☐ *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	✓ *Operating Agency*	☐ *Monthly*	✓ *Less than 100% Review*
	✓ *Sub-State Entity*	☐ *Quarterly*	✓ *Representative Sample; Confidence Interval =+/-*
	☐ *Other: Specify:*	✓ *Annually*	*15%*
		☐*Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	
			☐ *Other: Describe*

Add another Data Source for this performance measure

State:	
Effective Date	

Data Source DHHS Reviews	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	✓ *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	✓ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	✓ *Representative Sample; Confidence Interval =*
	☐ *Other: Specify:*	☐ *Annually*	*10%*
		✓ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	
			☐ *Other: Describe*
Data Aggregation and Analysis	***Responsible Party for data aggregation and analysis*** *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*	
	✓ *State Medicaid Agency*	☐ *Weekly*	
	✓ *Operating Agency*	☐ *Monthly*	
	✓ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	✓ *Annually*	
		✓ *Continuously and Ongoing*	
		☐ *Other: Specify:*	

Add another Performance measure (button to prompt another performance measure)

Performance Measure:	*Proportion of participants whose plans were re-written in a timely fashion.*		
Data Source DDSN QIO Reports	***Responsible Party for data collection/generation*** *(check each that*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*

State:	
Effective Date	

	applies)		
	☐ *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	✓ *Less than 100% Review*
	✓ *Sub-State Entity*	☐ *Quarterly*	✓ *Representative Sample; Confidence Interval= +/-*
	☐ *Other: Specify:*	✓ *Annually*	*15%*
		☐ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	
			☐ *Other: Describe*

Data Source DHHS Reviews	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	✓ *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	✓ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	✓ *Representative Sample; Confidence Interval =*
	☐ *Other: Specify:*	☐ *Annually*	*10%*
		✓ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	
			☐ *Other: Describe*
Data Aggregation and Analysis	***Responsible Party for data aggregation and analysis*** *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*	
	✓ *State Medicaid Agency*	☐ *Weekly*	
	✓ *Operating Agency*	☐ *Monthly*	
	✓ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	✓ *Annually*	

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

Performance Measure:	*Proportion of participants whose plans were updated as needs changed.*		
Data Source DDSN QIO Reports	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☐ *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	✓ *Less than 100% Review*
	✓ *Sub-State Entity*	☐ *Quarterly*	✓ *Representative Sample; Confidence Interval =+/-*
	☐ *Other: Specify:*	✓ *Annually*	*15%*
		☐*Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	
			☐ *Other: Describe*

Data Source DHHS Reviews	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	✓ *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	✓ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	✓ *Representative Sample; Confidence Interval =*
	☐ *Other: Specify:*	☐ *Annually*	*10%*
		✓ *Continuously and*	☐ *Stratified: Describe Groups*

State:	
Effective Date	

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

Performance Measure:	*Proportion of participants whose plans were monitored in accordance with State policy.*		
Data Source DDSN QIO Reports	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☐ *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	✓ *Less than 100% Review*
	✓ *Sub-State Entity Delmarva*	☐ *Quarterly*	✓ *Representative Sample; Confidence Interval =+/-*
	☐ *Other: Specify:*	✓ *Annually*	*15%*
		☐*Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	
			☐ *Other: Describe*

Data Source DHHS Review Reports	***Responsible Party for data collection/generation***	***Frequency of data collection/generation:*** *(check each that*	***Sampling Approach*** *(check each that applies)*

	(check each that applies)	*applies)*	
	✓ *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	✓ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	✓ *Representative Sample; Confidence Interval =*
	☐ *Other: Specify:*	☐ *Annually*	*10%*
		✓ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	
			☐ *Other: Describe*
Data Aggregation and Analysis	***Responsible Party for data aggregation and analysis*** *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*	
	✓ *State Medicaid Agency*	☐ *Weekly*	
	✓ *Operating Agency*	☐ *Monthly*	
	✓ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	✓ *Annually*	
		✓ *Continuously and Ongoing*	
		☐ *Other: Specify:*	

Performance Measure:	*Proportion of participants who received contact with the case manager in accordance with State policy.*		
Data Source DDSN QIO Reports	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☐ *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	✓ *Less than 100% Review*
	✓ *Sub-State Entity*	☐ *Quarterly*	✓ *Representative*

	Delmarva			*Sample; Confidence Interval =+/-*
	☐ *Other: Specify:*	✓ *Annually*		*15%*
		Continuously and Ongoing		☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*		
				☐ *Other: Describe*

Data Source DHHS Reviews	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	✓ *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	✓ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	✓ *Representative Sample; Confidence Interval =*
	☐ *Other: Specify:*	☐ *Annually*	*10%*
		✓ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	
			☐ *Other: Describe*

Data Source NCI Survey Question Responses	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☐ *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	✓ *Less than 100% Review*
	✓ *Sub-State Entity*	☐ *Quarterly*	✓ *Representative Sample; Confidence Interval =+/-*
	☐ *Other: Specify:*	☐ *Annually*	*15%*
		✓ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	
			☐ *Other: Describe*

State:	
Effective Date	

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

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

For each performance measure/indicator the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

Performance Measure:	*Proportion of participants who are receiving the services and supports as specified in their plans.*		
Data Source DDSN QIO Reports	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☐ *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	✓ *Less than 100% Review*
	✓ *Sub-State Entity Delmarva*	☐ *Quarterly*	✓ *Representative Sample; Confidence Interval = +/-*
	☐ *Other: Specify:*	✓ *Annually*	*15%*

State:	
Effective Date	

		Continuously and Ongoing	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	
			☐ *Other: Describe*

Data Source DHHS Review Reports	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	✓ *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	✓ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	✓ *Representative Sample; Confidence Interval =*
	☐ *Other: Specify:*	☐ *Annually*	*10%*
		✓ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	
			☐ *Other: Describe*
Data Aggregation and Analysis	***Responsible Party for data aggregation and analysis*** *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*	
	✓ *State Medicaid Agency*	☐ *Weekly*	
	✓ *Operating Agency*	☐ *Monthly*	
	✓ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	✓ *Annually*	
		✓ *Continuously and Ongoing*	
		☐ *Other: Specify:*	

Add another Performance measure (button to prompt another performance measure)

Performance Measure:	*Reports regarding the unavailability of specific service and supports.*		
Data Source Provider Unavailability Report	***Responsible Party for data collection/generation*** *(check each that*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*

	applies)		
	☐ *State Medicaid Agency*	☐ *Weekly*	✓ *100% Review*
	✓ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☐ *Other: Specify:*	☐ *Annually*	
		✓ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	
			☐ *Other: Describe*
Data Aggregation and Analysis	***Responsible Party for data aggregation and analysis*** *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*	
	☐ *State Medicaid Agency*	☐ *Weekly*	
	✓ *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	☐ *Annually*	
		☐ *Continuously and Ongoing*	
		✓ *Other: Specify:*	
		Bi-monthly	

a.i.e Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.

For each performance measure/indicator the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

Performance Measure:	*Proportion of Waiver participants who were offered choice of Waiver versus institutional care.*		
Data Source DDSN QIO Reports	***Responsible Party for data***	***Frequency of data collection/generation:***	***Sampling Approach*** *(check each that*

	collection/generation *(check each that applies)*	*(check each that applies)*	*applies)*
	☐ *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	✓ *Less than 100% Review*
	✓ *Sub-State Entity*	☐ *Quarterly*	✓ *Representative Sample; Confidence Interval =+/-*
	☐ *Other: Specify:*	✓ *Annually*	*15%*
		☐*Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	
			☐ *Other: Describe*

Add another Data Source for this performance measure

Data Source DHHS Reviews	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	✓ *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	✓ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	✓ *Representative Sample; Confidence Interval =*
	☐ *Other: Specify:*	☐ *Annually*	*10%*
		✓ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	
			☐ *Other: Describe*
Data Aggregation and Analysis	***Responsible Party for data aggregation and analysis*** *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*	
	✓ *State Medicaid Agency*	☐ *Weekly*	
	✓ *Operating Agency*	☐ *Monthly*	

	✓ *Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	☐ *Annually*	
		✓ *Continuously and Ongoing*	
		☐ *Other: Specify:*	

Add another Performance measure (button to prompt another performance measure)

Performance Measure:	*Proportion of Waiver participants who were offered choice among services and providers.*		
Data Source Delmarva Reports	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☐ *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	✓ *Less than 100% Review*
	✓ *Sub-State Entity*	☐ *Quarterly*	✓ *Representative Sample; Confidence Interval =+/-*
	☐ *Other: Specify:*	✓ *Annually*	*15%*
		☐*Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	
			☐ *Other: Describe*

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

			Interval =
	☐ *Other: Specify:*	☐ *Annually*	*10%*
		✓ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	
			☐ *Other: Describe*

Data Source NCI Surveys	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☐ *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	✓ *Less than 100% Review*
	✓ *Sub-State Entity*	☐ *Quarterly*	✓ *Representative Sample; Confidence Interval =+/-*
	☐ *Other: Specify:*	☐ *Annually*	*15%*
		✓ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	
			☐ *Other: Describe*
Data Aggregation and Analysis	***Responsible Party for data aggregation and analysis*** *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*	
	✓ *State Medicaid Agency*	☐ *Weekly*	
	✓ *Operating Agency*	☐ *Monthly*	
	✓ *Sub-State Entity*	☐*Quarterly*	
	☐ *Other: Specify:*	✓ *Annually*	
		✓ *Continuously and Ongoing*	
		☐ *Other: Specify:*	

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

b. Methods for Remediation/Fixing Individual Problems

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

DDSN Operations staff will address waiver problems when discovered. A log of participant specific problems and dates of corrective actions will be maintained and provided to the administrative agency at least quarterly.

b.ii Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)	***Responsible Party*** *(check each that applies)*	***Frequency of data aggregation and analysis:*** *(check each that applies)*
[redacted]	✓ *State Medicaid Agency*	☐ *Weekly*
[redacted]	✓ *Operating Agency*	☐ *Monthly*
[redacted]	✓ *Sub-State Entity*	✓ *Quarterly*
[redacted]	☐ *Other: Specify:*	✓ *Annually*
[redacted]		☐ *Continuously and Ongoing*
[redacted]		☐ *Other: Specify:*
[redacted]		

c. Timelines

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

○	**Yes** *(complete remainder of item)*
✓	**No**

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

Appendix E: Participant Direction of Services

[NOTE: *Complete Appendix E only when the waiver provides for one or both of the participant direction opportunities specified below.*]

Applicability *(select one)*:

✓	**Yes.** This waiver provides participant direction opportunities. Complete the remainder of the Appendix.
○	**No.** This waiver does not provide participant direction opportunities. Do not complete the remainder of the Appendix.

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

○	**Yes.** The State requests that this waiver be considered for Independence Plus designation.
✓	**No.** Independence Plus designation is not requested.

Appendix E-1: Overview

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

This Waiver proposes to offer In-Home Support as a participant directed service with employer authority. The participant or his/her representative can choose to direct the participant's service. The participant or representative must have no communication or cognitive deficits that would interfere with participant/representative directions.

Service Coordinators will provide detailed information to the Waiver participant and/or representative about participant direction including the benefits and responsibilities. If the participant or representative wants to pursue participant direction additional information about the risks, and liabilities will be shared by the Service Coordinator including the role of the Financial Manager and also the hiring, management, and firing of workers. Independent consultation and assistance is available at no cost to recipients who feel the need for additional support.

Once the participant has chosen to direct his/her services, the Service Coordinator(s) will continue to monitor service delivery and the status of the participant's health and safety.

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one:*

✓	**Participant – Employer Authority**. As specified in ***Appendix E-2, Item a,*** the participant (or the participant's representative) has decision-making authority over workers who provide

	waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
○	**Participant – Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
○	**Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies:*

✓	Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.
☐	Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.
☐	The participant direction opportunities are available to persons in the following other living arrangements *(specify)*:

d. Election of Participant Direction. Election of participant direction is subject to the following policy (*select one):*

○	Waiver is designed to support only individuals who want to direct their services.
○	The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.
✓	The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria. *Specify the criteria*:
	The Service Coordinator will determine if participants/representatives are interested and in need of In-Home Support. If so, their likely ability to direct those services will be assessed using a standardized assessment. The assessment will determine the participant's communication ability, cognitive patterns, mood/behavior and understanding of the service and role. When direction by a representative is desired, the tool assesses the representative's relationship and proximity/availability to the participant, ability to communicate and understanding of the service and role. Adverse recommendations are reviewed by a Human Rights Committee and disagreements regarding the results may be reconsidered/appealed.

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

At the time of the initial assessment, the Service Coordinator will introduce participant direction of In-Home Support and provide information about this option. The Service Coordinator will provide this information initially or at the request of the participant/representative. If the participant/representative

is interested the Service Coordinator will provide more details about the benefits and responsibilities of participant direction and determine continued interest. The Service Coordinator will provide extensive information about the benefits as well as the risks, responsibilities and liabilities of participant/representative direction.

f. Participant Direction by a Representative. Specify the State's policy concerning the direction of waiver services by a representative *(select one)*:

○	The State does not provide for the direction of waiver services by a representative.	
✓	The State provides for the direction of waiver services by a representative. Specify the representatives who may direct waiver services: *(check each that applies)*:	
	✓	Waiver services may be directed by a legal representative of the participant.
	✓	Waiver services may be directed by a non-legal representative freely chosen by an adult participant. Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:
		A participant may choose to have waiver services directed by a representative and he/she may choose anyone (subject to DDSN or Medicaid Policy) willing to understand and assume the risks, rights, and responsibilities of directing the participant's care. The chosen representative must demonstrate a strong personal commitment to the participant and knowledge of the participant's preferences, and must agree to a predetermined frequency of contact with the participant. "A representative may not be paid to be a representative, and may not be paid to provide waiver services to the participant.

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-3. *(Check the opportunity or opportunities available for each service)*:

Participant-Directed Waiver Service	Employer Authority	Budget Authority
In-Home Support	✓	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one:*

✓	**Yes**. Financial Management Services are furnished through a third party entity. *(Complete item E-1-i)*. Specify whether governmental and/or private entities furnish these services. *Check each that applies:*	
	✓	Governmental entities

✓	Private entities
○	**No**. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used. *Do not complete Item E-1-i.*

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. S*elect one*:

○	FMS are covered as the waiver service entitled _____ as specified in Appendix C-3. *Provide the following information:*
✓	FMS are provided as an administrative activity. *Provide the following information:*
i.	**Types of Entities**: Specify the types of entities that furnish FMS and the method of procuring these services:
	Vendors, government fiscal agents or agencies approved through a request for proposal (RFP) process.
ii.	**Payment for FMS**. Specify how FMS entities are compensated for the administrative activities that they perform:
	Contractual monthly fee
iii.	**Scope of FMS**. Specify the scope of the supports that FMS entities provide *(check each that applies):*
	Supports furnished when the participant is the employer of direct support workers:
	✓ Assist participant in verifying support worker citizenship status
	✓ Collect and process timesheets of support workers
	✓ Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance
	✓ Other *(specify):*
	Verify participant's/representative's verification of minimum qualifications.
	Supports furnished when the participant exercises budget authority:
	☐ Maintain a separate account for each participant's participant-directed budget
	☐ Track and report participant funds, disbursements and the balance-of participant funds
	☐ Process and pay invoices for goods and services approved in the service plan
	☐ Provide participant with periodic reports of expenditures and the status of the participant-directed budget
	☐ Other services and supports *(specify)*:
	Additional functions/activities:
	☐ Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency

	✓	Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency
	☐	Provide other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget
	☐	Other *(specify)*:
iv.	**Oversight of FMS Entities.** Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.	
	An annual independent audit is required to verify that expenditures are accounted for and disbursed according to General Accepted Accounting Practices.	

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☐	**Case Management Activity**. Information and assistance in support of participant direction are furnished as an element of Medicaid case management services. *Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:*
☐	**Waiver Service Coverage**. Information and assistance in support of participant direction are provided through the waiver service coverage (s) specified in Appendix C-3 entitled:
✓	**Administrative Activity**. Information and assistance in support of participant direction are furnished as an administrative activity. *Specify: (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:*
	The FMS supports are provided by a contractor, vendor or governmental entity. The operating agency will have a contract with the FMS to provide these supports. The supports include providing each participant with a checklist of responsibilities they have in hiring their workers, and verification of qualifications and requirements The operating agency will assess the performance of the FMS on a quarterly basis. The FMS is also required to have an independent financial audit every year.

k. Independent Advocacy *(select one)*.

✓	**Yes.** Independent advocacy is available to participants who direct their services. *Describe the nature of this independent advocacy and how participants may access this advocacy*:

	The Center for Disability Resources at the University of South Carolina. This advocacy is accessed through the Service Coordinator.
○	**No.** Arrangements have not been made for independent advocacy.

l. Voluntary Termination of Participant Direction. Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

The Service Coordinator will accommodate the participant by providing a list of qualified providers from which a provider can be selected in order to maintain service delivery. The Service Coordinator and the operating agency will work together to ensure the health and safety of the participant in this transition and will work to avoid any break in service delivery.

m. Involuntary Termination of Participant Direction. Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

If through regular monitoring questions arise about the health, safety, and welfare of a participant who receives In-Home Support, the Service Coordinator will utilize the standardized assessment to re-assess the participant's/representative's ability to direct the service. When the results of the assessment indicate an in ability to direct the services and a Human Rights Committee concurs, the Service Coordinator will transition from participant./representative direction to agency directed services. The Service Coordinator will update the plan of service to include any necessary measures to be taken until the transition is completed.

n. Goals for Participant Direction. In the following table, provide the State's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	**Budget Authority Only or Budget Authority in Combination with Employer Authority**
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1	230	0
Year 2	330	0
Year 3	360	0
Year 4 (renewal only)		
Year 5 (renewal only)		

Appendix E-2: Opportunities for Participant-Direction

a. Participant – Employer Authority *(Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b)*

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Check each that applies:*

☐	**Participant/Co-Employer**. The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions. *Specify the types of agencies (a.k.a., "agencies with choice") that serve as co-employers of participant-selected staff; the standards and qualifications the State requires of such entities and the safeguards in place to ensure that individuals maintain control and oversight of the employee:*
✓	**Participant/Common Law Employer**. The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Check the decision making authorities that participants exercise*:

✓	Recruit staff
☐	Refer staff to agency for hiring (co-employer)
✓	Select staff from worker registry
✓	Hire staff (common law employer)
✓	Verify staff qualifications
✓	Obtain criminal history and/or background investigation of staff. Specify how the costs of such investigations are compensated:
	The cost for background checks will be handled by DDSN.
✓	Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-3.
✓	Determine staff duties consistent with the service specifications in Appendix C-3.
☐	Determine staff wages and benefits subject to applicable State limits
✓	Schedule staff
✓	Orient and instruct-staff in duties
✓	Supervise staff

✓	Evaluate staff performance
✓	Verify time worked by staff and approve time sheets
✓	Discharge staff (common law employer)
☐	Discharge staff from providing services (co-employer)
☐	Other *(specify)*:

b. Participant – Budget Authority *(Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b)*

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Check all that apply*:

☐	Reallocate funds among services included in the budget
☐	Determine the amount paid for services within the State's established limits
☐	Substitute service providers
☐	Schedule the provision of services
☐	Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-3
☐	Specify how services are provided, consistent with the service specifications contained in Appendix C-3
☐	Identify service providers and refer for provider enrollment
☐	Authorize payment for waiver goods and services
☐	Review and approve provider invoices for services rendered
☐	Other *(specify):*

ii. Participant-Directed Budget. Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

iii. Informing Participant of Budget Amount. Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

iv. Participant Exercise of Budget Flexibility. *Select one:*

○	The participant has the authority to modify the services included in the participant-directed budget without prior approval. Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:
○	Modifications to the participant-directed budget must be preceded by a change in the service plan.

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

The Waiver participant or the parents/legal guardian of the Waiver participant is informed of this decision in writing when an adverse decision is made. The formal process of review and adjudication of actions/determinations is done under the authority of the SC Code Ann. §1-23-310 thru 1-23-400, (Supp 2007) and 27 SC Code Ann. Regs. 126-150 thru 126-158 (1976)

The notice used to offer individuals the opportunity to request a Fair Hearing is called "SCDDSN Reconsideration Process and SCDHHS Medicaid Appeals Process". It states:

A request for reconsideration of an adverse decision **must be** sent in writing to the State Director at SCDDSN, P. O. Box 4706, Columbia, SC 29240. The SCDDSN reconsideration process **must be** completed in its entirety before seeking an appeal from the South Carolina Department of Health and Human Services (SCDHHS).

A formal request for a reconsideration must be made in writing within thirty (30) calendar days of receipt of written notification of the adverse decision. The request must state the basis of the complaint, previous efforts to resolve the complaint and the relief sought. The reconsideration request must be dated and signed by the consumer, representative, or person assisting the consumer in filing the request. If necessary, staff will assist the consumer in filing a written reconsideration.

Note: In order for waiver benefits/services to continue during the reconsideration/appeal process, the consumer/representative's request for reconsideration must be submitted within ten (10) calendar days of the written notification of the adverse decision. If the adverse action is upheld, the consumer/representative may be required to repay waiver benefits received during the reconsideration/appeal process.

The State Director or his designee shall issue a written decision within ten (10) working days of receipt of the written reconsideration request and shall communicate this decision to the consumer/representative. If the State Director upholds the original adverse action/decision, the reason(s) shall be specifically identified in the written decision.

If the consumer/representative fully completes the above reconsideration process and is dissatisfied with the results, the consumer/representative has the right to request an appeal with the SCDHHS. The purpose of an administrative appeal is to prove error in fact or law. The consumer/representative must submit a written request to the following address no later than thirty (30) calendar days from the receipt of the SCDDSN written reconsideration decision.

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

The consumer/representative must attach copy of the written reconsideration notifications received from the SCDDSN regarding the specific matter on appeal. In the appeal request the consumer/representative must clearly state with specificity, which issue(s) the consumer/representative wishes to appeal.

Unless the request is made to the above address within thirty (30) calendar days of the receipt of the SCDDSN written reconsideration decision, the SCDDSN decision will be final and binding. An appeal request is considered filed at the above address if postmarked by the thirtieth (30th) calendar day following receipt of the SCDDSN written reconsideration decision. The consumer/representative shall be advised by the SCDHHS Division of Appeals and Hearings as to the status of the appeal request.

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one*:

○	**Yes**. The State operates an additional dispute resolution process *(complete Item b)*
✓	**No**. This Appendix does not apply (*do not complete Item b)*

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

✓	**Yes.** The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver *(complete the remaining items)*.
○	**No.** This Appendix does not apply (*do not complete the remaining items*)

b. Operational Responsibility. Specify the State agency that is responsible for the operation of the grievance/complaint system:

DDSN

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

DDSN's Department Directive 535-08-DD establishes the procedures to assure concerns are handled appropriately and in a timely manner. The types of concerns handled through this process may include but are not limited to concerns about service planning, restrictions of personal rights and freedoms, program, support and placement decisions, access to files/records or ability to give informed consent. People are encouraged to seek remediation through their service provider first. If not resolved, the matter is referred to DDSN. Appropriate DDSN staff will contact the person expressing the concern, review/research the concern and attempt to mediate a resolution. Concerns involving the health, safety, or welfare of the person will receive immediate review and, as needed, necessary actions will be taken.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program. *Select one*:

✓	**Yes**. The State operates a Critical Event or Incident Reporting and Management Process *(complete Items b through e)*
○	**No**. This Appendix does not apply (*do not complete Items b through e). If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.*

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents, and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The South Carolina Child Protection Reform Act as specified in S.C. Code Ann. Section 20-7-480, (2007) et seq., requires reporting of abuse, neglect and exploitation to those state agencies having statutory authority to receive reports and investigate allegations of suspected abuse, neglect or exploitation. The two state agencies are the SC Department of Social Services (Child Protective Services) and local and state law enforcement. The South Carolina Omnibus Adult Protection Act as specified in S.C. Code Ann. Section 43-35-5 (2006), et seq., Section 43-35-10, requires the reporting of suspected abuse, neglect, or exploitation of a vulnerable adult, age 18 and above. These agencies include Adult Protective Services - South Carolina Department of Social Services (DSS) and local and state law enforcement agencies. The appropriate reporting agency is determined by the age of the victim, suspected perpetrator, and the location of the alleged incident. These reports can be made by phone or written form. All verbal reports shall subsequently be submitted in writing. These incidents are defined as physical abuse, or psychological abuse, threatened or sexual abuse, neglect, and exploitation. Mandatory reporters have a duty to report if they have information, facts or evidence that would lead a reasonable person to believe that a child or vulnerable adult has been or is at risk for abuse, neglect or exploitation. Mandated reporters are defined as professional staff, employees, and volunteers or contract provider agencies having a legal responsibility under state law to report suspected abuse, neglect, or exploitation to state investigative agencies. Mandated reporters must make the report within 24 hours or the next business day after discovery of the abuse, neglect or exploitation.

The reporting of Critical Incidents (100-09-DD) must be followed. A critical incident is an "unusual, unfavorable occurrence that is: a) not consistent with routine operations; b) has harmful or otherwise negative effects involving people with disabilities, employees, or property; and c)

occurs in a DDSN Regional Center, DSN Board facility, other service provider facility, or during the direct provision of DDSN funded services (e.g., if a child receiving service coordination services sustains a serious injury while the service coordinator is in the child's home, then it should be reported as a critical incident; however if the service coordinator is not in the home when the injury occurred then it would not be reported)". An example of a critical incident includes but is not limited to possession of firearms, weapons or explosives or consumer accidents which result in serious injury requiring hospitalization or medical treatment from injuries received. Reports of critical incidents are required to be made to the operating agency within 24 hours or the next business day of the event.

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

Waiver participants and/or their family members and legal representatives are provided written information about what constitutes abuse, how to report, and to whom to report. They are informed of their rights annually, this information is explained by their Service Coordinators.

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time frames for responding to critical events or incidents, including conducting investigations.

When there is reason to believe that a child has been abused, neglected, or exploited, in the home or other community setting, employees and other mandated reporters have a duty to report according to established procedures and state law. DSS is the mandated agency to investigate suspected abuse, neglect, or exploitation in these settings. DDSN/DHHS and its contract provider agencies shall be available to provide information and assistance to DSS. Procedures have been established for DDSN/DHHS to assist contract provider agencies in resolving issues with DSS regarding intake referrals and investigations. DSS will conduct a complete investigation and contact law enforcement if criminal violations are suspected. If the investigation is substantiated, notification is sent to appropriate agencies for personnel and other required actions to be taken. If the alleged perpetrator is also employed by DDSN or DHHS, a contract provider agency, or the family and abuse, neglect, or exploitation is substantiated, the employee will be terminated.

When there is reason to believe that an adult has been abused, neglected or exploited, mandated reporters have a duty to make a report to DSS or local law enforcement. All alleged abuse and other critical events are also reported to the operating agency within 24 hours. DDSN works closely with DSS and local law enforcement regarding critical events and/or incidents. On a regular basis, DDSN quality management staff review critical incidents, analyze data for trends, and recommend changes in policy, practice, or training that may reduce the risk of such events occurring in the future. Statewide trend data is provided to DSN Boards and contracted service providers to enhance awareness activities as a prevention strategy. Each regional center, DSN Board or contracted service provider will also utilize their respective risk managers and committees to regularly review all critical incidents for trends and to determine if the recommendations made in the final written reports were actually implemented and are in effect.

e. Responsibility for Oversight of Critical Incidents and Events. Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

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

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

Protection and Advocacy for People with Disabilities, Inc.
Protection and Advocacy for People with Disabilities (P&A) has statutory authority to investigate abuse and neglect of people with disabilities.

In addition, the DDSN Division of Quality Management maintains information on the incidence of abuse, neglect, or exploitation, including trend analyses to identify and respond to patterns of abuse, neglect, or exploitation. All data collected is considered confidential and is used in developing abuse prevention programs. All reports of abuse, neglect or exploitation are reviewed for consistency and completeness to assure the victim is safe, and to take immediate personnel action. DDSN requires that all identified alleged perpetrators be placed on administrative leave without pay until the investigation is completed. Periodic audits of the abuse reporting system are conducted to ensure compliance with state law.

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions

a. Use of Restraints or Seclusion *(select one):*

✓	The State does not permit or prohibits the use of restraints or seclusion. Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints or seclusion and how this oversight is conducted and its frequency:
	The operating agency (DDSN) is responsible for oversight. DDSN contracts with the service coordination provider to monitor the Support Plan which includes asking the participant and their representative their satisfaction with service delivery on an ongoing basis. This plan will be reviewed by the Service Coordinator and the operating agency prior to implementation to ensure it does not contain any restraint or seclusion interventions. Furthermore, DDSN contracts with two nationally certified behavioral analysts who review a sample of every Behavior Support providers' records to ensure they do not include a restrictive intervention as a means of improving behavior.
○	The use of restraints or seclusion is permitted during the course of the delivery of waiver services. Complete Items G-2-a-i and G-2-a-ii:

i. Safeguards Concerning the Use of Restraints or Seclusion. Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints or seclusion). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for overseeing the use of restraints or seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

b. Use of Restrictive Interventions

✓	The State does not permit or prohibits the use of restrictive interventions. Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

	The operating agency (DDSN) is responsible for oversight. DDSN contracts with the service coordination provider to monitor the Support Plan which includes asking the participant and their representative their satisfaction with service delivery on an ongoing basis. This plan will be reviewed by the Service Coordinator and the operating agency prior to implementation to ensure it does not contain any restraint or seclusion interventions. Furthermore, DDSN contracts with two nationally certified behavioral analysts who review a sample of every Behavior Support providers' records to ensure they do not include restraints or seclusion as a means of improving behavior.
	The use of restrictive interventions is permitted during the course of the delivery of waiver services. Complete Items G-2-b-i and G-2-a-ii:

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G-3: Medication Management and Administration

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

○	**Yes**. This Appendix applies *(complete the remaining items)*.
✓	**No**. This Appendix is not applicable *(do not complete the remaining items)*.

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one*:

○	Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications. *(complete the remaining items)*
○	Not applicable (*do not complete the remaining items*)

ii. State Policy. Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

iii. Medication Error Reporting. *Select one of the following:*

○	Providers that are responsible for medication administration are required to *both* record and report medication errors to a State agency (or agencies). *Complete the following three items:*
	(a) Specify State agency (or agencies) to which errors are reported:
	(b) Specify the types of medication errors that providers are required to *record:*
	(c) Specify the types of medication errors that providers must *report* to the State:
○	Providers responsible for medication administration are required to *record* medication errors but make information about medication errors available only when requested by the State. Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: **Health and Welfare**
The State, on an ongoing basis, identifies, addresses and seeks to prevent the occurrence of abuse, neglect and exploitation.

a.i *For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

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

Performance Measure:	*Number and proportion of incidents of reported abuse, neglect, and exploitation.*		
Data Source [e.g. – examples cited in IPG] DDSN Reports	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☐ *State Medicaid Agency*	☐ *Weekly*	✓ *100% Review*
	✓ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☐ *Other: Specify:*	☐ *Annually*	
		✓ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	
			☐ *Other: Describe*
Data Aggregation and Analysis	***Responsible Party for data aggregation and analysis*** *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*	
	☐ *State Medicaid Agency*	☐ *Weekly*	
	✓ *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	*Quarterly*	
	☐ *Other: Specify:*	✓ *Annually*	
		Continuously and Ongoing	
		☐ *Other: Specify:*	

Add another Data Source for this performance measure

Add another Performance measure (button to prompt another performance measure)

Performance Measure:	*Number of incidents of abuse, neglect , or exploitation that are reported within required timeframe..*		
Data Source	***Responsible Party for***	***Frequency of data***	***Sampling Approach***

[e.g. – examples cited in IPG] DDSN reports	***data collection/generation*** *(check each that applies)*	***collection/generation:*** *(check each that applies)*	*(check each that applies)*
	☐ *State Medicaid Agency*	☐ *Weekly*	✓ *100% Review*
	✓ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☐ *Other: Specify:*	☐ *Annually*	
		✓ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	
			☐ *Other: Describe*
Data Aggregation and Analysis	***Responsible Party for data aggregation and analysis*** *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*	
	☐ *State Medicaid Agency*	☐ *Weekly*	
	✓ *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	*Quarterly*	
	☐ *Other: Specify:*	✓ *Annually*	
		Continuously and Ongoing	
		☐ *Other: Specify:*	

Performance Measure:	*Number of incidents of abuse, neglect, or exploitation in which the internal review was completed within required timeframe.*		
Data Source [e.g. – examples cited in IPG] DDSN reports	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☐ *State Medicaid Agency*	☐ *Weekly*	✓ *100% Review*
	✓ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☐ *Other: Specify:*	☐ *Annually*	

State:	
Effective Date	

		✓ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	
			☐ *Other: Describe*
Data Aggregation and Analysis	***Responsible Party for data aggregation and analysis*** *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*	
	☐ *State Medicaid Agency*	☐ *Weekly*	
	✓ *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	*Quarterly*	
	☐ *Other: Specify:*	✓ *Annually*	
		☐*Continuously and Ongoing*	
		☐ *Other: Specify:*	
Performance Measure:	*Number of incidents of abuse, neglect, or exploitation in which the internal review was completed within required timeframe.*		
Data Source [e.g. – examples cited in IPG] DDSN reports	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☐ *State Medicaid Agency*	☐ *Weekly*	✓ *100% Review*
	✓ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☐ *Other: Specify:*	☐ *Annually*	
		✓ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	
			☐ *Other: Describe*
Data Aggregation and Analysis	***Responsible Party for data aggregation and analysis*** *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*	
	☐ *State Medicaid Agency*	☐ *Weekly*	
	✓ *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	*Quarterly*	

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

Performance Measure:	*Proportion of people who report they are treated with dignity.*		
Data Source [e.g. – examples cited in IPG] HSRI Reports	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☐ *State Medicaid Agency*	☐ *Weekly*	☐*100% Review*
	☐*Operating Agency*	☐ *Monthly*	✓ *Less than 100% Review*
	✓ *Sub-State Entity*	☐ *Quarterly*	✓ *Representative Sample; Confidence Interval =*
	☐ *Other: Specify:*	☐ *Annually*	*15%*
		✓ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	
			☐ *Other: Describe*
Data Aggregation and Analysis	***Responsible Party for data aggregation and analysis*** *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*	
	☐ *State Medicaid Agency*	☐ *Weekly*	
	✓ *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	*Quarterly*	
	☐ *Other: Specify:*	✓ *Annually*	
		Continuously and Ongoing	
		☐ *Other: Specify:*	

Performance Measure:	*Number and proportion of critical incidents reported (including mortality, injuries, and client to client altercations).*

State:	
Effective Date	

Data Source [e.g. – examples cited in IPG] DDSN reports	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☐ *State Medicaid Agency*	☐ *Weekly*	✓ *100% Review*
	✓ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☐ *Other: Specify:*	☐ *Annually*	
		✓ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	
			☐ *Other: Describe*
Data Aggregation and Analysis	***Responsible Party for data aggregation and analysis*** *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*	
	☐ *State Medicaid Agency*	☐ *Weekly*	
	✓ *Operating Agency*	☐ *Monthly*	
	☐ *Sub-State Entity*	*Quarterly*	
	☐ *Other: Specify:*	✓ *Annually*	
		Continuously and Ongoing	
		☐ *Other: Specify:*	

Performance Measure:	*Proportion who have a primary care physician of their choice.*		
Data Source [e.g. – examples cited in IPG] DDSN data	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☐ *State Medicaid Agency*	☐ *Weekly*	*100% Review*
	☐*Operating Agency*	☐ *Monthly*	✓ *Less than 100% Review*

	✓ *Sub-State Entity*	☐ *Quarterly*	✓ *Representative Sample; Confidence Interval =+/-*
	☐ *Other: Specify:*	✓ *Annually*	*15%*
		Continuously and Ongoing	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	
			☐ *Other: Describe*
Data Aggregation and Analysis	***Responsible Party for data aggregation and analysis*** *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*	
	☐ *State Medicaid Agency*	☐ *Weekly*	
	✓ *Operating Agency*	☐ *Monthly*	
	✓ *Sub-State Entity*	*Quarterly*	
	☐ *Other: Specify:*	✓ *Annually*	
		Continuously and Ongoing	
		☐ *Other: Specify:*	

Performance Measure:	*Proportion of people who feel safe in their homes and neighborhood.*		
Data Source [e.g. – examples cited in IPG] HSRI Reports	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☐ *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	✓ *Less than 100% Review*
	✓ *Sub-State Entity Delmarva*	☐ *Quarterly*	✓ *Representative Sample; Confidence Interval =+/-*
	☐ *Other: Specify:*	☐ *Annually*	*15%*
		✓ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	

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

Performance Measure:	*Proportion of people who feel safe in their homes and neighborhood.*		
Data Source [e.g. – examples cited in IPG] HSRI Reports	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☐ State Medicaid Agency	☐ Weekly	100% Review
	Operating Agency	☐ Monthly	✓ Less than 100% Review
	✓ Sub-State Entity	☐ Quarterly	✓ Representative Sample; Confidence Interval =+/-
	☐ Other: Specify:	☐ Annually	15%
		✓ Continuously and Ongoing	☐ Stratified: Describe Groups
		☐ Other: Specify:	
			☐ Other: Describe
Data Aggregation and Analysis	***Responsible Party for data aggregation and analysis*** *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*	
	☐ State Medicaid Agency	☐ Weekly	
	✓ Operating Agency	☐ Monthly	
	☐ Sub-State Entity	Quarterly	
	☐ Other: Specify:	✓ Annually	

		Continuously and Ongoing	
		☐ *Other: Specify:*	

Performance Measure:	*Proportion of participants that receive the recommended preventive dental visits.*		
Data Source [e.g. – examples cited in IPG] HSRI reports	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☐ *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	✓ *Less than 100% Review*
	✓ *Sub-State Entity*	☐ *Quarterly*	✓ *Representative Sample; Confidence Interval =+/-*
	☐ *Other: Specify:*	☐ *Annually*	*15%*
		✓ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	
			☐ *Other: Describe*
Data Aggregation and Analysis	***Responsible Party for data aggregation and analysis*** *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*	
	☐ *State Medicaid Agency*	☐ *Weekly*	
	✓ *Operating Agency*	☐ *Monthly*	
	☐*Sub-State Entity*	☐ *Quarterly*	
	☐ *Other: Specify:*	✓ *Annually*	
		☐*Continuously and Ongoing*	
		☐ *Other: Specify:*	

Performance Measure:	*Proportion of participants whom report that they know their rights.*		
Data Source [e.g. – examples cited in IPG]	***Responsible Party for data collection/generation***	***Frequency of data collection/generation:*** *(check each that*	***Sampling Approach*** *(check each that applies)*

HSRI Reports	*(check each that applies)*	*applies)*	
	☐ *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	✓ *Less than 100% Review*
	✓ *Sub-State Entity Delmarva*	☐ *Quarterly*	✓ *Representative Sample; Confidence Interval =+/-*
	☐ *Other: Specify:*	*Annually*	*15%*
		✓ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	
			☐ *Other: Describe*
Data Aggregation and Analysis	***Responsible Party for data aggregation and analysis*** *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*	
	☐ *State Medicaid Agency*	☐ *Weekly*	
	✓ *Operating Agency*	☐ *Monthly*	
	Sub-State Entity	*Quarterly*	
	☐ *Other: Specify:*	✓ *Annually*	
		Continuously and Ongoing	
		☐ *Other: Specify:*	

Performance Measure:	*Proportion of participants that report concerns by type.*		
Data Source [e.g. – examples cited in IPG] DDSN Reports	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☐ *State Medicaid Agency*	☐ *Weekly*	*100% Review*
	✓ *Operating Agency*	☐ *Monthly*	✓ *Less than 100% Review*
	Sub-State Entity	☐ *Quarterly*	✓ *Representative Sample; Confidence Interval =*
	☐ *Other: Specify:*	*Annually*	*15%*
		✓ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*

State:	
Effective Date	

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

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

b. Methods for Remediation/Fixing Individual Problems

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

As abuse, neglect, and exploitation are identified, action is taken to protect the health and welfare of the participant. Data is collected and analyzed for trends, and strategies are developed and implemented to prevent future occurrences.

b.ii Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend	***Responsible Party*** *(check each that applies)*	***Frequency of data aggregation and analysis:*** *(check each that*

identification)		*applies)*
	☐ *State Medicaid Agency*	☐ *Weekly*
	✓ *Operating Agency*	☐ *Monthly*
	☐ *Sub-State Entity*	☐ *Quarterly*
	☐ *Other: Specify:*	✓ *Annually*
		☐ *Continuously and Ongoing*
		☐ *Other: Specify:*

c. Timelines

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

○	**Yes** *(complete remainder of item)*
✓	**No**

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

Appendix H: Systems Improvement

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QMS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based *discovery* activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the QMS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QMS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program.

H.1 Systems Improvement

The objective of the State's Quality Management Systems is to a quickly and reliability identify with strong confidence both positive and adverse trends allowing for necessary adjustments to enhance the overall performance of the system.

The State's system improvement activities are purposefully designed to ensure that they are across all six (6) CMS assurances – functioning effectively and efficiently based performance measures. Data undergoes rigorous reliability and validity testing to ensure that the aggregated information used to drive policy and procedures decisions will yield their intended increase performance.

Timely analyzed discovery and remediation aggregated data allows the state to take the necessary swift action to improve the system's performance, thereby learn how to improve meaningful outcomes for participants in the home and community based waivers administered by DHHS and operated by DDSN.

The state is able to stratify information related to each approved waiver program and is also able to stratify by provider, service group, and assurance. Because the State's Quality Management System was designed over eight (8) years ago with adjustments made as needed to ensure its overall effectiveness, to include aligning it to the CMS quality frame work, we have strong formal processes and activities in place for trending, prioritizing, and implementing system improvements.

The following activities are conducted by the specified agency at the frequency indicated:
1. Evaluation of Need:
a. LOC Evaluations
Operating Agency – Quarterly
State Medicaid Agency – Monthly
b. Re-evaluations conducted at least annually
Operating Agency – Monthly
State Medicaid Agency – Annually
c. LOC – Instruments/Process are followed
Operating Agency – Annually
State Medicaid Agency - Monthly

2. Service Plans:
a. Service plans are reviewed periodically to assume all needs addressed and references considered.
Operating Agency – Quarterly
State Medicaid Agency – Annually
b. Service plans developed according to policies
Operating Agency – Quarterly
State Medicaid Agency-Annually
c. Service plans revised when needed
Operating Agency – Quarterly
State Medicaid Agency-Annually

d. Services in plan are implemented
Operating Agency – Quarterly
State Medicaid Agency-Annually
3. Qualified Providers:
a. Documentation that providers meet/licensing/certification is present
Operating Agency – Annually
Other (DHEC) – Annually
State Medicaid Agency – Other 9-18 months or more frequent if problems
b. Documentation that non-licensed/non-certified providers are monitored periodically.
Operating Agency – Annually
State Medicaid Agency – 9-18 months or more frequent if problems
c. Documentation of monitoring and training and actions when providers have not met requirements.
Operating Agency – Bi-annually
State Medicaid Agency – Bi-annually
4. Abuse and Neglect
a. Abuse, neglect, and exploitation are identified, action taken to protect health and welfare, and analysis of trends and strategies to prevent are implemented.
State Operating Agency
Other (DSS, local law enforcement) – Quarterly
Quality improvement committee – Annually
State Medicaid Agency – Annually
PDD Waiver
MR/RD Waiver
HASCI
5. State submits evidence of its monitoring of all delegated functions
DHHS
6. The state has an adequate system for assuring financial accountability.
a. The state submits results of its financial monitoring process for verifying maintenance of appropriate financial records as specified in the approved waiver.
The MR/RD Waiver 372 Lag Report
Operating Agency – Annually
State Medicaid Agency
The service coordinator/early interventionist is responsible for monitoring all waiver services to ensure they are provided and authorized according to their definition. An authorization for services is completed and sent to the provider of choice. Providers use the prior authorization number when they submit claims to receive Medicaid reimbursement.
b. The state submits results of its review of waiver participant claims to verify that they are coded and paid in accordance with the waiver methodology.
A "recipient special program (RSP) indicator of MMIS identifies individuals to the MMIS system as waiver clients and processes claims accordingly
Operating Agency – Quarterly
State Medicaid Agency
Providers
SCDHHS submits debit adjustments against providers due to incorrect billings.
State Medicaid Agency – Monthly

SCDHHS program integrity will independently review the records to ensure claims are paid according to wavier methodology

State Medicaid Agency

Others as warranted

c. The state demonstrated that interviews with state staff and providers are periodically conducted to verify that any identified financial irregularities are addressed.

In order to ensure authorization forms are completed correctly, SCDDSN expects the quality contractor, Delmarva, to monitor compliance during reviews. Indicator G9-16 monitors the authorizations to ensure they are completed as required and prior to any service provision.

d. The state demonstrates that site visits are conducted with providers to verify that they maintain financial records according to provider agreements/contracts.

Each month, SCDDSN receives a report of all services paid by Medicaid during the prior month for consumers enrolled in the Waiver. From this report, a smaller report of direct-billed services is extracted. Each board receives a report that lists services to be credited each month called a "Waiver Credit Report". This report shows the amounts paid by Medicaid for each participant by social security number, fund code, service date, participant name, procedure code, units, amount paid, participant provider number and goop provider number. It also shows the calculated total credit for the DSN Board. A credit is processed through SCDDSN accounts payable for each board based on the total. Waiver Credit Reports are mailed to the boards each month.

H.1.a.ii

System Improvement Activities	***Responsible Party*** *(check each that applies*	***Frequency of monitoring and analysis*** *(check each that applies*
[redacted]	✓ *State Medicaid Agency*	*Weekly*
[redacted]	✓ *Operating Agency*	✓ *Monthly*
[redacted]	☐ *Sub-State Entity*	✓ *Quarterly*
[redacted]	☐ *Quality Improvement Committee*	✓ *Annually*
[redacted]	✓ *Other: Specify:*	☐ *Other: Specify:*
[redacted]	*SCDHEC*	
[redacted]	*Providers*	

H.1.b.i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes, and how the results of the changes and the assessment are communicated (and with what frequency) to stakeholders, including participants, families, providers, agencies and other interested parties. If applicable, include the State's targeted standards for systems improvement.

The State Medicaid Agency and the Operating Agency meet every other month to monitor and analyze the effectiveness of system design changes. Any changes recommended of the overall system's design or any sub-systems are brought to the DHHS/DDSN Policy Committee which meets quarterly for discussion and action.

DDSN has two (2) advisory groups that provided input into the initial and ongoing changes to the quality management system, one of which was founded through the efforts of a CMS Real Choice Systems Change Grant. They are comprised of 51% or greater of primary customers and family members, providers, state Medicaid agency, and DDSN staff and advocacy organizations. They meet twice a year.

The second advisory group is comprised of provider organizations and operating agency staff and Medicaid agency. The meet quarterly to review results of the CMS assurance data and to make recommendations to prioritize system improvement strategies based on aggregated and analyzed discovery and remediation data.

H.1.b.ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

Each year, the operating agency's quality improvement organization conducts two (2) studies using random sampling regression analysis techniques to determine if the state's quality management system is performing as expected. It helps us to determine if modifications made to the system's design yield the intended results.

Appendix I: Financial Accountability

APPENDIX I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The State employs several methods to ensure the integrity of payments made for waiver services in different departments within the agency. Following are descriptions of the methods employed:

The State has a memorandum of agreement with the operating agency, DDSN, to assure provider qualifications for the provision of most waiver services. For all other waiver services the State Medicaid Agency directly assures that those providers meet the qualifications. DDSN maintains a quality review process utilizing their quality assurance contractor to ensure provider qualifications are valid and appropriate. The review consists of three components: staffing review, administrative review and participant review. The staffing review samples staff member at different levels to ensure they meet all initial training and certification requirements, tuberculin skin test requirements, ongoing training requirements and all other requirements. The administrative review determines that all agency administrative requirements (liability insurance, list of officers, written by-laws, emergency back-up plans, etc.) have been met. The participant review verifies that all requirements relating to the actual conduct of service have been met.

The Division of Program Integrity at DHHS responds to complaints and allegations of inappropriate or excessive billings by Medicaid providers, and also collects and analyzes provider data in order to identify billing exceptions and deviations. In this capacity, Program Integrity any audit payments to service providers. Issues that involve fraudulent billing by providers are turned over to the Medicaid Fraud Control Unit in the South Carolina Attorney General's Office. In addition, The Division of Audits reviews DHHS contracts with external entities in order to ensure that contract terms are met and only allowable costs are charged. Additionally, The Internal Audit Division within SCDDSN has included in it audit plan planned audits of State Agency Medicaid contracts.

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: **Financial Accountability**
State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.

a.i *For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).*

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

Performance Measure:	*Proportion of paid claims that are coded and paid in accordance with policies in the approved waiver.*		
Data Source [e.g. – examples cited in IPG] DDSN web based adjustments	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	☐ *State Medicaid Agency*	☐ *Weekly*	✓ *100% Review*
	✓ *Operating Agency*	☐ *Monthly*	☐ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	☐ *Representative Sample; Confidence Interval =*
	☐ *Other: Specify:*	☐ *Annually*	
		✓ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	
			☐ *Other: Describe*

Add another Data Source for this performance measure

Data Source DDSN/QIO Adjustment Logs	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*

	☐ *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	✓ *Operating Agency*	☐ *Monthly*	✓ *Less than 100% Review*
	✓ *Sub-State Entity*	✓ *Quarterly*	✓ *Representative Sample; Confidence Interval =*
	☐ *Other: Specify:*	☐ *Annually*	*15%*
		✓ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	
			☐ *Other: Describe*

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

Data Source DHHS Review Reports/Special Investigations	***Responsible Party for data collection/generation*** *(check each that applies)*	***Frequency of data collection/generation:*** *(check each that applies)*	***Sampling Approach*** *(check each that applies)*
	✓ *State Medicaid Agency*	☐ *Weekly*	☐ *100% Review*
	☐ *Operating Agency*	☐ *Monthly*	✓ *Less than 100% Review*
	☐ *Sub-State Entity*	☐ *Quarterly*	✓ *Representative Sample; Confidence Interval =*
	☐ *Other: Specify:*	☐ *Annually*	*10%*
		✓ *Continuously and Ongoing*	☐ *Stratified: Describe Groups*
		☐ *Other: Specify:*	
			☐ *Other: Describe*
Data Aggregation and Analysis	***Responsible Party for data aggregation and analysis*** *(check each that applies*	***Frequency of data aggregation and analysis:*** *(check each that applies*	
	✓ *State Medicaid Agency*	☐ *Weekly*	
	✓ *Operating Agency*	☐ *Monthly*	
	✓ *Sub-State Entity*	✓ *Quarterly*	
	☐ *Other: Specify:*	☐ *Annually*	
		✓ *Continuously and Ongoing*	
		☐ *Other: Specify:*	

Add another Performance measure (button to prompt another performance measure)

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

DDSN's Internal Audit division does periodic reviews of billing system and contracted providers to insure billings are appropriate. These audits are conducted using a selected sample. Findings are shared with DHHS in a timely manner.

b. Methods for Remediation/Fixing Individual Problems

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

Upon review and approval by DHHS, financial policies and procedures are reviewed and updated to prevent future occurrences.

b.ii Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)	***Responsible Party*** *(check each that applies)*	***Frequency of data aggregation and analysis:*** *(check each that applies)*
	☐ *State Medicaid Agency*	☐ *Weekly*
	✓ *Operating Agency*	☐ *Monthly*
	☐ *Sub-State Entity*	☐ *Quarterly*
	☐ *Other: Specify:*	☐ *Annually*
		☐ *Continuously and Ongoing*
		✓ *Other: Specify:*
		Periodic

c. Timelines

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

○	**Yes** *(complete remainder of item)*
✓	**No**

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

APPENDIX I-2: Rates, Billing and Claims

a. Rate Determination Methods. In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

The Bureau of Reimbursement Methodology and Policy, with assistance from DDSN, is responsible for the development of waiver service payment rates. The Bureau of Reimbursement Methodology operates under the direction of the South Carolina Department of Health and Human Services. DHHS also has retained the services of an actuarial firm to assist in such efforts as needed. The Medicaid agency allows the public to offer comments on waiver rate changes and rate setting methodology either through Medical Care Advisory Committee meetings, public hearings, or through meetings with association representatives.

For waiver services provided by DDSN, rates were established based upon the projected costs of the service to be provided and actual service costs of similar service waiver rates. Projected costs used in the determination of the waiver rates include salaries, fringe benefits, travel, training, and indirect costs. Billable units were determined in order to adjust for time spent on leave, training, travel, and administration. Both DDSN and the Bureau of Reimbursement Methodology perform financial reviews on an as needed basis to ensure that funding provided by the South Carolina General Assembly was appropriately expended by providers of these services.

For services provided by private providers, rates were established to coincide with those paid for similar services rendered in other CLTC waiver programs (ex. adult day care, personal care services).

b. Flow of Billings. Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Providers maintain the option of billing directly to the Medicaid agency or they may voluntarily reassign their right to direct payments to the Department of Disabilities and Special Needs. Providers billing Medicaid directly may bill either by use of a CMS 1500 form or by the State's electronic billing system.

c. Certifying Public Expenditures *(select one)*:

●	**Yes**. Public agencies directly expend funds for part or all of the cost of waiver services and certify their public expenditures (CPE) in lieu of billing that amount to Medicaid (*check each that applies*):
■	**Certified Public Expenditures (CPE) of State Public Agencies**. Specify: (a) the public agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (*Indicate source of revenue for CPEs in Item I-4-a.*)
	(a) The South Carolina Department of Disabilities and Special Needs (SCDDSN). (b) SCDDSN files annual cost reports that report the total costs incurred for both their institutional services (ie ICF/MRs) and all waiver services providers. (c) The SCDDSN received state appropriations for these services in SFY 2008/2009. The contract between SCDHHS and SCDDSN applicable to these services will require the following contract language: "SCDDSN agrees to incur expenditures from state appropriated funds and/or funds derived from tax revenue in an amount at least equal to the non-federal share of the allowable, reasonable, and necessary cost for the provision of services to be provided to Medicaid recipients under the contract prior to submitting claims under the contract. Documentation of the non-federal expenditures necessary to support the claims for reimbursement must be maintained by SCDDSN and are subject to audit by SCDHHS. SCDHHS may withhold and/or recoup reimbursements if Certified Public Expenditures are not adequately documented. As required by 42 CFR Part 201.5, all funds expended for the non-federal share of this contract must be in compliance with 42 CFR Part 433 Subpart B. Such non-federal funds must be actually expended for the provision of services under this contract". Additionally, the Internal Audit Division within the SCDHHS has included in its' audit plan planned audits of State Agency Medicaid contracts.
☐	**Certified Public Expenditures (CPE) of Non-State Public Agencies**. Specify: (a) the non-State public agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (*Indicate source of revenue for CPEs in Item I-4-b.*)
○	**No**. Public agencies do not certify expenditures for waiver services.

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

Claims for waiver services are submitted to MMIS through either the use of a CMS 1500 form or through the State's electronic billing system. Providers of waiver services are given a service authorization, which reflects the service identified on the service plan. This authorization is produced by the case manager and contains the amount, frequency, date and type of service authorized along with a unique authorization number, in addition to monitoring service delivery. Once the claim is submitted to MMIS, payment is made to the provider only if the participant was Medicaid eligible on the date of service and there is an indication in MMIS that the participant is enrolled in the waiver program. This is the case for all claims.

The DHHS Division of Program Integrity conducts post-payment reviews. These reviews sample claims and determine if services have been billed as authorized.

The DDSN internal audit division periodically conducts audits of DDSN's billing system to ensure billing is appropriate for the service provided.

e. Billing and Claims Record Maintenance Requirement. Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §74.53.

APPENDIX I-3: Payment

a. Method of payments — MMIS *(select one)*:

●	Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).
○	Payments for some, but not all, waiver services are made through an approved MMIS. Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64.
○	Payments for waiver services are not made through an approved MMIS. Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:
○	Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS. Describe how payments are made to the managed care entity or entities:

b. Direct payment. Payments for waiver services are made utilizing one or more of the following arrangements (*check each that applies*):

■	The Medicaid agency makes payments directly to providers of waiver services.
☐	The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.
■	The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent. Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:
	DDSN contracts with a financial management services entity to make payments for in-home support services delivered by individuals rather than agencies. These individuals document service delivery and provide data to the financial management service. This information is transferred to DDSN, which in turn bills MMIS for services rendered. The FMS cuts checks biweekly and transfers funds to workers by direct deposit. Financial audits are performed periodically.
☐	Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity. Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

○	**No**. The State does not make supplemental or enhanced payments for waiver services.
●	**Yes**. The State makes supplemental or enhanced payments for waiver services. Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made and (b) the types of providers to which such payments are made. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.
	Only SCDDSN waiver services will be reimbursed retrospectively for its total allowable Medicaid costs incurred of providing services under this waiver. Therefore, the supplemental payment will equate to a cost settlement that will be determined upon the completion of the SCDHHS review of the annual cost report submitted by the SCDDSN.

d. Payments to Public Providers. *Specify whether public providers receive payment for the provision of waiver services.*

●	**Yes.** Public providers receive payment for waiver services. Specify the types of public providers that receive payment for waiver services and the services that the public providers furnish. *Complete item I-3-e.*
	SCDDSN will receive payment and provide the waiver services <u>except</u> for Adult Day Health Care services, Personal Care services, Adult Day Health Care Nursing, Adult Day Health Care Transportation, DME Specialized Medical Equipment, Supplies, Assistive Technology and Appliances. These services will be provided by private Medicaid providers directly enrolled in the Medicaid program.
○	**No**. Public providers do not receive payment for waiver services. *Do not complete Item I-3-e.*

e. **Amount of Payment to Public Providers**. Specify whether any public provider receives payments (including regular and any supplemental payments) that in the aggregate *exceed* its reasonable costs of providing waiver services and, if so, how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one*:

○	The amount paid to public providers is the same as the amount paid to private providers of the same service.
○	The amount paid to public providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.
●	The amount paid to public providers differs from the amount paid to private providers of the same service. When a public provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report. Describe the recoupment process:
	SCDDSN will submit annual cost reports that reflect the total costs incurred by SCDDSN and/or its local Boards of the services provided under this waiver. The SCDHHS will desk review the cost report and determine the average unit cost of the services provided under this waiver based upon costs and units of the total population served (i.e. both Medicaid and non-Medicaid recipients). The actual cost rate will then be compared against the interim rate paid to determine an overpayment or underpayment. If an overpayment occurs, the SCDHHS will recoup the federal portion of the overpayment from the SCDDSN and return it to CMS via the quarterly expenditure report.

f. **Provider Retention of Payments.** Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

●	Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.
○	Providers do not receive and retain 100 percent of the amount claimed to CMS for waiver services. Provide a full description of the billing, claims, or payment processes that result in less than 100% reimbursement of providers. Include: (a) the methodology for reduced or returned payments; (b) a complete listing of types of providers, the amount or percentage of payments that are reduced or returned; and, (c) the disposition and use of the funds retained or returned to the State (i.e., general fund, medical services account, etc.):
○	Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment. Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

●	**Yes**. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e). Specify the governmental agency (or agencies) to which reassignment may be made.
	The Department of Disabilities and Special Needs
○	**No**. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.

ii. Organized Health Care Delivery System. *Select one:*

●	**Yes**. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10. Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:
	(a) DDSN operates as an organized health care delivery system (OHCDS). This system of care is comprised of DDSN and the local DSN County Boards and together they form an OHCDS. The OHCDS establishes contracts with other qualified providers to furnish home and community based services to people served in this waiver. (b) Providers of waiver services may direct bill their services to DHHS. (c) At a minimum, waiver participants are given a choice of providers, regardless of their affiliate with the OHCDS, annually or more frequent if requested or warranted (d) DDSN will assure that providers that furnish waiver services under contract with the OHCDS meet applicable provider qualifications through the state's procurement process. (e) DDSN assures that contracts with providers meet applicable requirements via an annual quality assurance review of the provider, as well as periodic record reviews. (f) DDSN requires its local DSN County Boards to perform annual financial audits.
○	**No**. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

○	The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may *voluntarily* elect to receive *waiver* and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.
○	This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain *waiver* and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.
●	The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.

APPENDIX I-4: Non-Federal Matching Funds

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the State source or sources of the non-federal share of computable waiver costs. *Check each that applies:*

☐	**Appropriation of State Tax Revenues to the State Medicaid agency**
■	**Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.** If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by public agencies as CPEs, as indicated in Item I-2-c:
	The South Carolina Department of Disabilities and Special Needs (SCDDSN) received state appropriations to provide services under this waiver. A portion of these funds will be transferred to the South Carolina Department of Health and Human Services (SCDHHS) via an IGT for payments that will be made directly to private providers enrolled with the SCDHHS. For services provided by SCDDSN, these funds will be directly expended by SCDDSN as CPE.
☐	**Other State Level Source(s) of Funds.** Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by public agencies as CPEs, as indicated in Item I-2- c:

b. Local or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Check each that applies:*

☐	**Appropriation of Local Revenues.** Specify: (a) the local entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by public agencies as CPEs, as specified in Item I-2- c:
☐	**Other non-State Level Source(s) of Funds.** Specify: (a) the source of funds; (b) the entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and /or, indicate if funds are directly expended by public agencies as CPEs, as specified in Item I-2- c:
■	**Not Applicable**. There are no non-State level sources of funds for the non-federal share.

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources. *Check each that applies.*

☐	Provider taxes or fees
☐	Provider donations
☐	Federal funds (other than FFP)
	For each source of funds indicated above, describe the source of the funds in detail:
■	None of the foregoing sources of funds contribute to the non-federal share of computable waiver costs.

APPENDIX I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

●	No services under this waiver are furnished in residential settings other than the private residence of the individual. (*Do not complete Item I-5-b*).
○	As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual. (*Complete Item I-5-b*)

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

APPENDIX I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver.
Select one:

○	**Yes**. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services. *The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:*
●	**No.** The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.

APPENDIX I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing

a. Co-Payment Requirements. Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services as provided in 42 CFR §447.50. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

●	**No**. The State does not impose a co-payment or similar charge upon participants for waiver services. (*Do not complete the remaining items; proceed to Item I-7-b*).
○	**Yes**. The State imposes a co-payment or similar charge upon participants for one or more waiver services. (*Complete the remaining items*)

i. Co-Pay Arrangement Specify the types of co-pay arrangements that are imposed on waiver participants *(check each that applies)*:

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*	
☐	Nominal deductible
☐	Coinsurance
☐	Co-Payment
☐	Other charge *(specify)*:

ii Participants Subject to Co-pay Charges for Waiver Services. Specify the groups of waiver participants who are subject to charges for the waiver services specified in Item I-7-a-iii and the groups for whom such charges are excluded. The groups of participants who are excluded must comply with 42 CFR §447.53.

iii. Amount of Co-Pay Charges for Waiver Services. In the following table, list the waiver services for which a charge is made, the amount of the charge, and the basis for determining the charge. The amount of the charge must comply with the maximum amounts set forth in 42 CFR §447.54.

Waiver Service	Amount of Charge	Basis of the Charge

iv. Cumulative Maximum Charges. Indicate whether there is a cumulative maximum amount for all co-payment charges to a waiver participant *(select one)*:

○	There is no cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant.
○	There is a cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant. Specify the cumulative maximum and the time period to which the maximum applies:

v. Assurance. In accordance with 42 CFR §447.53(e), the State assures that no provider may deny waiver services to an individual who is eligible for the services on account of the individual's inability to pay a cost-sharing charge for a waiver service.

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants as provided in 42 CFR §447.50. *Select one:*

●	**No**. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.
○	**Yes**. The State imposes a premium, enrollment fee or similar cost-sharing arrangement. Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income as set forth in 42 CFR §447.52; (c) the groups of participants subject to cost-sharing and the groups who are excluded (groups of participants who are excluded must comply with 42 CFR §447.53); and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality D

Appendix J: Cost Neutrality Demonstration

Appendix J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the following table for each year of the waiver.

Level(s) of Care *(specify)*:							
Col. 1	**Col. 2**	**Col. 3**	**Col. 4**	**Col. 5**	**Col. 6**	**Col. 7**	**Col. 8**
Year	**Factor D**	**Factor D′**	**Total: D+D′**	**Factor G**	**Factor G′**	**Total: G+G′**	**Difference (Column 7 less Column 4)**
1	$6,605	$8,004	$14,609	$102,220	$2,063	$104,283	$89,674
2	$7,509	$8,244	$15,753	$105,287	$2,125	$107,412	$91,659
3	$8,903	$8,491	$17,394	$108,446	$2,189	$110,635	$93,241
4							
5							

Appendix J-2 - Derivation of Estimates

a. Number Of Unduplicated Participants Served. Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (From Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	Level of Care:
Year 1	2,530	ICF/MR	
Year 2	3,630	ICF/MR	
Year 3	3,960	ICF/MR	
Year 4 (renewal only)			
Year 5 (renewal only)			

b. Average Length of Stay. Describe the basis of the estimate of the average length of stay on the waiver by participants in Item J-2-d.

These calculated lengths of stay are based on the projected entry of participants into the Community Support Waiver. In Year 1 there will be a gradual entry of participants through out the year.
Year 1 – 8.65 months
Year 2 – 10.20 months
Year 3 – 11.50 months

c. Derivation of Estimates for Each Factor. Provide a narrative description for the derivation of the estimates of the following factors.

i. Factor D Derivation. The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

The estimates are based on projected utilization of services. The projected utilizations are based on current industry practices for each service level included in the waiver. The costs per services were determined by surveying current provider of services.

ii. Factor D′ Derivation. The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The derivation of the figures originates with the CMS 372 Report for Waiver #0237.90 for the year ending 6/30/2006 with an inflation factor of 3% for the 2nd and 3rd year. This waiver serves participants with the same level of care (ICF/MR).

AVERAGE PER CAPITA EXPENDITURES BY FISCAL YEAR:

1ST YEAR OF WAIVER	$ 8,004 * 1.00 =	$8,004
2ND YEAR OF WAIVER	$ 8,004 * 1.03 =	$8,244
3RD YEAR OF WAIVER	$ 8,244 * 1.03 =	$8,491

iii. Factor G Derivation. The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

2007 ICF/MR Cost Reports and the 2007 Preliminary Cost Reports.
The 2007 Cost Report is on file at Department of Health and Human Service.
.

AVERAGE PER CAPITA EXPENDITURES BY FISCAL YEAR:

1ST YEAR OF WAIVER	$102,220 * 1.00 =	$102,220
2ND YEAR OF WAIVER	$102,220 * 1.03 =	$105,287
3RD YEAR OF WAIVER	$105,287 * 1.03 =	$108,446

iv. Factor G′ Derivation. The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The derivations of the figures originate with the CMS 372 Report for Waiver #0237.90 for the year ending 6/30/2006 with an inflation factor of 3% for the 2nd and 3rd year. This waiver serves participants with the same level of care (ICF/MR).

AVERAGE PER CAPITA EXPENDITURES BY FISCAL YEAR:

1ST YEAR OF WAIVER	$2,063 * 1.00 =	$2,063
2ND YEAR OF WAIVER	$2,063 * 1.03 =	$2,125
3RD YEAR OF WAIVER	$2,125* 1.03 =	$2,189

d. Estimate of Factor D. *Select one:* Note: Selection below is new.

●	The waiver does not operate concurrently with a §1915(b) waiver. Complete Item J-2-d-i
○	The waiver operates concurrently with a §1915(b) waiver. Complete Item J-2-d-ii

i. Estimate of Factor D – Non-Concurrent Waiver. Complete the following table for each waiver year

Waiver Year: Year 1					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Personal Care 1	**Per Hour**	**23**	**182**	**12.00**	**50,232**
Personal Care 2	**Per Hour**	**230**	**182**	**16.00**	**669,760**
Respite Non-Institution Day	**Per Day**	**345**	**26**	**80.00**	**717,600**
Respite Non-Institution Hour	**Per Hour**	**92**	**285**	**10.50**	**275,310**
Respite Institution ICF/MR	**Per Day**	**12**	**26**	**270.00**	**84,240**
Respite Institution Nursing Home	**Per Day**	**12**	**26**	**120.00**	**37,440**
Environmental Modification	**Per Item**	**35**	**1**	**7,500.00**	**262,500**
Specialized Med. Equip/Supplies	**Per Item**	**817**	**1**	**1,800.00**	**1,470,600**
Psychological Services	**Per Hour**	**12**	**35**	**60.00**	**25,200**
Private Vehicle Modification	**Per Item**	**12**	**1**	**7,500.00**	**90,000**
Behavior Supports	**Per Hour**	**23**	**35**	**60.00**	**48,300**
Day Activity	**Per Unit**	**690**	**182**	**22.75**	**2,856,945**
Career Preparation	**Per Unit**	**943**	**182**	**22.75**	**3,904,492**
Community Services	**Per Unit**	**230**	**182**	**22.75**	**952,315**
Employment Services - Group	**Per Unit**	**104**	**35**	**22.75**	**82,810**
Employment Services-Individual	**Per Hour**	**104**	**182**	**80.00**	**1,514,240**
Support Center Services	**Per Unit**	**230**	**182**	**22.75**	**952,315**
In Home Support – Self Directed	**Per Hour**	**230**	**182**	**12.30**	**514,878**
Adult Day Health Care	**Per Day**	**92**	**138**	**45.50**	**577,668**
Adult Day Health Care-Transportation	**Per Day**	**46**	**138**	**15.00**	**95,220**
Adult Day Health Care - Nursing	**Per Day**	**5**	**138**	**15.00**	**10,350**
GRAND TOTAL:					**$15,192,415**
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					**2,530**
FACTOR D (Divide grand total by number of participants)					**$6,005**

Waiver Year: Year 1					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
AVERAGE LENGTH OF STAY ON THE WAIVER					**8.65 months**

State:	
Effective Date	

Waiver Year: Year 2					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Total Cost
Personal Care 1	Per Hour	33	214	12.00	84,744
Personal Care 2	Per Hour	330	214	16.00	1,129,920
Respite Non-Institution Day	Per Day	495	31	80.00	1,227,600
Respite Non-Institution Hour	Per Hour	132	336	10.50	465,696
Respite Institution ICF/MR	Per Day	17	31	270.00	142,290
Respite Institution Nursing Home	Per Day	17	31	120.00	63,240
Environmental Modification	Per Item	50	1	7,500.00	375,000
Specialized Med. Equip/Supplies	Per Item	1,172	1	1,800.00	2,109,600
Psychological Services	Per Hour	17	41	60.00	41,820
Private Vehicle Modification	Per Item	17	1	7,500.00	127,500
Behavior Supports	Per Hour	33	41	60.00	81,180
Day Activity	Per Unit	990	214	22.75	4,819,815
Career Preparation	Per Unit	1,270	214	22.75	6,182,995
Community Services	Per Unit	330	214	22.75	1,606,605
Employment Services - Group	Per Unit	149	41	22.75	138,980
Employment Services - Individual	Per Hour	149	214	80.00	2,550,880
Support Center Services	Per Unit	330	214	22.75	1,606,605
In Home Support – Self Directed	Per Hour	330	214	12.30	868,626
Adult Day Care Health	Per Day	132	163	45.50	978,978
Adult Day Health Care-Transportation	Per Day	66	163	15.00	161,370
Adult Day Health Care - Nursing	Per Day	7	163	15.00	17,115
GRAND TOTAL:					$24,780,559
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					3,630
FACTOR D (Divide grand total by number of participants)					$6,827
AVERAGE LENGTH OF STAY ON THE WAIVER					10.20 months

State:	
Effective Date	

Waiver Year: Year 3					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Total Cost
Personal Care 1	Per Hour	36	242	12.60	109,771
Personal Care 2	Per Hour	360	242	16.80	1,463,616
Respite Non-Institution Day	Per Day	540	35	84.00	1,587,600
Respite Non-Institution Hour	Per Hour	144	380	11.03	603,562
Respite Institution ICF/MR	Per Day	18	35	283.50	178,605
Respite Institution Nursing Home	Per Day	18	35	126.00	79,380
Environmental Modification	Per Item	54	1	7,500.00	405,000
Specialized Med. Equip/Supplies	Per Item	1,278	1	1,800.00	2,300,400
Psychological Services	Per Hour	18	46	63.00	52,164
Private Vehicle Modification	Per Item	18	1	7,500.00	135,000
Behavior Supports	Per Hour	36	46	63.00	104,328
Day Activity	Per Unit	1,080	242	23.89	6,243,890
Career Preparation	Per Unit	1,476	242	23.89	8,533,317
Community Services	Per Unit	360	242	23.89	2,081,297
Employment Services - Group	Per Unit	162	46	23.89	178,028
Employment Services - Individual	Per Hour	162	242	84.00	3,293,136
Support Center Services	Per Unit	360	242	23.89	2,081,297
In Home Support – Self Directed	Per Hour	360	242	12.92	1,125,590
Adult Day Care Health	Per Day	144	184	47.78	1,265,979
Adult Day Health Care-Transportation	Per Day	72	184	15.75	208,656
Adult Day Health Care - Nursing	Per Day	7	184	15.75	20,286
GRAND TOTAL:					$32,050,902
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					3,960
FACTOR D (Divide grand total by number of participants)					$8,094
AVERAGE LENGTH OF STAY ON THE WAIVER					11.50 months

State:	
Effective Date	

State:	
Effective Date	