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 waivers target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

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

Request for an Amendment to a §1915(c) Home and Community-Based Services Waiver

1. Request Information

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

B. Program Title:
Community Supports (CS) Waiver

C. Waiver Number:SC.0676

D. Amendment Number:SC.0676.R02.02

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

07/01/19

Approved Effective Date: 03/09/20

Approved Effective Date of Waiver being Amended: 07/01/17

2. Purpose(s) of Amendment

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

The State is seeking to amend the Community Supports (CS) Waiver to update language related to the Waiver Case Management Service, increase the period of time a participant may go without receiving a service before being dis-enrolled (upon initial enrollment only)and update rates for a number of services.

Also, the State is updating language surrounding Conflict Free Case Management.

3. Nature of the Amendment

A. Component(s) of the Approved Waiver Affected by the Amendment. This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently *(check each that applies):*

Component of the Approved Waiver	Subsection(s)
☐ Waiver Application	
☐ Appendix A	

Component of the Approved Waiver	Subsection(s)
Waiver Administration and Operation	
☒ Appendix B Participant Access and Eligibility	B-3c, B-6aii., B-6h.
☒ Appendix C Participant Services	C-1a.-c., C-1/C-3
☒ Appendix D Participant Centered Service Planning and Delivery	D-1a., D1-b, D-1c.- D-1g. D-2a.-b.
☐ Appendix E Participant Direction of Services	
☐ Appendix F Participant Rights	
☐ Appendix G Participant Safeguards	
☐ Appendix H	
☒ Appendix I Financial Accountability	I-2a., I-2d.
☒ Appendix J Cost-Neutrality Demonstration	

B. Nature of the Amendment. Indicate the nature of the changes to the waiver that are proposed in the amendment *(check each that applies):*

- ☐ **Modify target group(s)**
- ☐ **Modify Medicaid eligibility**
- ☐ **Add/delete services**
- ☐ **Revise service specifications**
- ☐ **Revise provider qualifications**
- ☐ **Increase/decrease number of participants**
- ☐ **Revise cost neutrality demonstration**
- ☐ **Add participant-direction of services**
- ☐ **Other**

Specify:

1. Request Information (1 of 3)

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

B. Program Title (*optional - this title will be used to locate this waiver in the finder*):

Community Supports (CS) Waiver

C. Type of Request: amendment

Requested Approval Period:*(For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)*

○ **3 years** ◉ **5 years**

Waiver Number:SC.0676.R02.02
Draft ID: SC.012.02.02

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

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 07/01/17
Approved Effective Date of Waiver being Amended: 07/01/17

1. Request Information (2 of 3)

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

☐ **Hospital**
Select applicable level of care

○ **Hospital as defined in 42 CFR §440.10**
If applicable, specify whether the state additionally limits the waiver to subcategories of the hospital level of care:

○ **Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160**

☐ **Nursing Facility**
Select applicable level of care

○ **Nursing Facility as defined in 42 CFR ??440.40 and 42 CFR ??440.155**
If applicable, specify whether the state additionally limits the waiver to subcategories of the nursing facility level of care:

○ **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**

☒ **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**
If applicable, specify whether the state additionally limits the waiver to subcategories of the ICF/IID level of care:

Not Applicable

1. Request Information (3 of 3)

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs)

approved under the following authorities

Select one:

- (●) **Not applicable**
- ( ) **Applicable**

Check the applicable authority or authorities:

- [ ] **Services furnished under the provisions of §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)(2) (central broker)**
  - [ ] **§1915(b)(3) (employ cost savings to furnish additional services)**
  - [ ] **§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:

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

- [x] **This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

2. Brief Waiver Description

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

Administrative authority for this waiver is 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 has 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 Disabilities and Special Needs (DSN) Boards and private providers as waiver service providers.

The CS waiver offers the opportunity for participant/responsible party direction of the In-Home Support service; other services are provider
managed.

The State reserves capacity in the CS waiver for the following scenarios: individuals receiving state-funded day services and individuals currently enrolled in the ID/RD waiver who choose to enroll in the CS waiver, Military personnel and family residing in SC.

The original effective date for the CS waiver was July 1, 2009.

3. Components of the Waiver Request

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

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

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

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

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

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

- (●) **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ( ) **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

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

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

H. Quality Improvement Strategy. Appendix H contains the Quality Improvement Strategy for this waiver.

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

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

4. Waiver(s) Requested

A. Comparability. The state requests a waiver of the requirements contained in §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)*:

- ○ **Not Applicable**
- ◉ **No**
- ○ **Yes**

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

- ◉ **No**
- ○ **Yes**

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

☐ **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the state.
Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:

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

5. Assurances

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

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

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

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

C. Evaluation of Need: The state assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

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

1. Informed of any feasible alternatives under the waiver; and,

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

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

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

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

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

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

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

6. Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including state plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

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

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

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

E. Free Choice of Provider. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the state has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

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

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

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

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

The amendments were presented to the Tribal Council on October 25, 2017 and the Medical Care Advisory Committee (MCAC) on November 14, 2017. The amendments were posted for public comment December 11, 2017 for 30 days.

The comments gathered were as follows:
SUMMARY OF FEEDBACK RECEIVED
SCDHHS received questions regarding SCDDSN's designation as an OHCDS.

SCDHHS RESPONSE
It is the intention of SCDHHS to allow SCDDSN to operate as an OHCDS as it executes its operational responsibilities related to the ID/RD and CS Waivers.

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

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

7. Contact Person(s)

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

Last Name: Abney

First Name: Michelle

Title: Waiver Administrator

Agency: South Carolina Department of Health and Human Services

Address: PO Box 8206

Address 2:

City: Columbia

State: **South Carolina**

Zip: 29202

Phone: (803) 898-2804 **Ext:** ☐ **TTY**

Fax: (803) 255-8204

E-mail: Michelle.Abney@scdhhs.gov

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

Last Name: Priest

First Name: Janet

Title: Director, ID/RD Division

Agency: South Carolina Department of Disabilites and Special Needs

Address: PO Box 4706

Address 2:

City: Columbia

State: **South Carolina**

Zip: 29240

Phone: (803) 898-9620 **Ext:** ☐ **TTY**

Fax: (803) 898-9660

E-mail: jpriest@ddsn.sc.gov

8. Authorizing Signature

This document, together with the attached revisions to the affected components of the waiver, constitutes the state's request to amend its approved waiver under §1915(c) of the Social Security Act. The state affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The state further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The state certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

Signature: Joshua Baker

State Medicaid Director or Designee

Submission Date: Mar 4, 2020

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

Last Name: BAKER

First Name: JOSHUA

Title: AGENCY DIRECTOR

Agency: SOUTH CAROLINA DEPT. OF HEALTH AND HUMAN SERVICES

Address: 1801 MAIN STREET

Address 2: JEFFERSON SQUARE

City: COLUMBIA

State: **South Carolina**

Zip: 29202

Phone: (803) 898-2504 **Ext:** ☐ **TTY**

Fax:

(803) 898-2504

E-mail:

JOSHUA.BAKER@SCDHHS.GOV

Attachments

Attachment #1: Transition Plan

Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

- ☐ **Replacing an approved waiver with this waiver.**
- ☐ **Combining waivers.**
- ☐ **Splitting one waiver into two waivers.**
- ☐ **Eliminating a service.**
- ☐ **Adding or decreasing an individual cost limit pertaining to eligibility.**
- ☒ **Adding or decreasing limits to a service or a set of services, as specified in Appendix C.**
- ☐ **Reducing the unduplicated count of participants (Factor C).**
- ☐ **Adding new, or decreasing, a limitation on the number of participants served at any point in time.**
- ☐ **Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.**
- ☐ **Making any changes that could result in reduced services to participants.**

Specify the transition plan for the waiver:

A transition plan is not required because the limits are being increased.

Attachment #2: Home and Community-Based Settings Waiver Transition Plan

Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.

To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.

Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.

Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

South Carolina Department of Health and Human Services
Community Supports (CS) Waiver
Transition Plan
December 2016

1. Introduction

The Center for Medicare and Medicaid Services (CMS) issued a final rule on Home and Community-Based Services (HCBS) establishing certain requirements for services that are provided through Medicaid waivers, like the Community Supports (CS) Waiver. There are specific requirements for where home and community-based services are received which will be referred to as the “settings requirements.”

1.1. Home and Community Based Settings Requirements
CMS has listed the following as the requirements of all home and community-based (HCB) settings. They must have the following qualities (per 42 CFR 441.301 (c)(4)):
- The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.
- The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.
- Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.
- Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.
- Facilitates individual choice regarding services and supports, and who provides them.

1.2. Initial Plan Development
CMS requires that each state submit a “Transition Plan” for each waiver renewal or amendment. The Transition Plan outlines how the state will come into conformance and compliance with the HCBS Rule settings requirements. The state must also submit a “Statewide Transition Plan” that outlines how the state will come into conformance with the new requirements of the HCBS Rule for all of its 1915(c) waivers. States must come into full compliance with HCBS Rule requirements by Mar. 17, 2019.

This is the Transition Plan for the CS Waiver Renewal. Per CMS requirements, this is available for the public to read and comment on before being submitted to CMS for review when the renewal is submitted.

SCDHHS formed a workgroup to address and solicit input on how the state could come into compliance with the HCBS rule. This group is composed of members from:
- SC Department of Health and Human Services
- SC Department of Mental Health
- SC Department of Disabilities and Special Needs
- SC Vocational Rehabilitation Department
- Other governmental partners
- Advocacy groups:
  - AARP South Carolina
  - Family Connection of South Carolina
  - Protection & Advocacy of People with Disabilities, Inc.
  - Able South Carolina
- Providers:
  - Local Disabilities and Special Needs Boards
  - Housing providers for mentally ill population
  - Adult Day Health Care Providers
  - Private Providers of Medicaid and HCBS services
- Beneficiaries and family members

The large workgroup broke into sub-groups to address different tasks of coming into compliance with the HCBS Rule. The large group meets monthly to discuss the progress of the sub-groups and to examine issues, concerns and the overall vision of how the state can come into compliance with the new regulation. This includes opportunities to comment on the current Statewide

Transition Plan. The CS waiver transition plan was modeled after the Statewide Transition Plan.

The Transition Plan may change as the state goes through the process of coming into compliance with the HCBS Rule. If this plan undergoes any substantive changes after submission to CMS, the state will make it available again for public comment and input.

South Carolina assures that the settings transition plan included in this waiver renewal will be subject to any provisions or requirements included in South Carolina's approved Statewide Transition Plan. South Carolina will implement any required changes upon approval of the Statewide Transition Plan and will make conforming changes to its waiver when it submits the next amendment or renewal.

2. Communications and Outreach – Public Notice Process

2.1 Public Notice and Comment on CS Waiver Renewal and Transition Plan
SCDHHS developed policy to provide multiple methods of public notice and input on waiver renewals which also includes the accompanying transition plan.
• The Medical Care Advisory Committee (MCAC) was provided advisories on the CS waiver renewal and transition plan on November 15, 2016.
• Per 42 CFR 441.304 (f)(4), Tribal Notification was provided via email on December 6, 2016 and on conference call on December 14, 2016.
• A webinar was held on December 22, 2016. This meeting was recorded and made available for viewing, along with a transcript of the recording, on the DHHS website: http://www.scdhhs.gov
• A public meeting was held to discuss the CS waiver renewal and its transition plan on January 5, 2017 in Columbia, SC.
• Public notice for comment on the CS waiver renewal and transition plan was sent out via the SCDHHS listserv on December 16, 2017.
• Public notice for comment on the CS waiver renewal and transition plan was posted on the SCDHHS website on December 16, 2017. (http://www.scdhhs.gov)
• Public notice on the CS waiver renewal and transition plan, including the draft waiver application document and the waiver transition plan document, was posted on the following websites on December 19, 2016:
o Family Connection of SC website (http://www.familyconnectionsc.org)
o Developmental Disabilities Council website (http://www.scddc.state.sc.us/index.html)
• Printed public notice on the CS waiver renewal and transition plan was posted at SCDHHS Jefferson Square/Headquarters Lobby on December 16, 2016.
• A printed copy of the CS waiver renewal document and waiver transition plan document were made available for public view and comment at SCDHHS Jefferson Square/Headquarters Lobby on December 16, 2016.
• Printed copies of public notice on the CS waiver renewal and transition plan was disseminated to all 413 CLTC Regional offices on December 16, 2017.
• Public comments were gathered from the public meeting and from electronic communications sent to SCDHHS, and from any communications mailed to SCDHHS. They are compiled into a document and attached here.
•
SCDHHS reviewed the comments and they are incorporated below.

3. Assessment of System-Wide Regulations, Policies, Licensing Standards, and Other Regulations

3.1 Process of System-Wide Review
As part of the larger scope of the Statewide Transition Plan, SCDHHS reviewed the regulations, policies, standards, and other provider requirements that directly impact the home and community-based settings of the CS waiver. They were read and reviewed to determine that the regulation, policy, etc. is not a barrier to the settings standards outlined in the HCBS Rule. The settings for South Carolina, as they relate to this waiver, are:
• Day Services Facilities:
o Adult Activity Centers (AAC)
o Work Activity Centers (WAC)
o Unclassified Programs
o Sheltered Workshops
• Adult Day Health Care Centers

A report was developed detailing the relevant laws, regulations, policies, standards, and directives that correspond with each HCBS settings requirement. A committee of external stakeholders (including providers, advocates, and other state agencies)

reviewed the system-wide assessment and document. That group provided feedback to verify the findings of the SCDHHS review. Changes and clarifications to the systemic assessment were made based on the external stakeholder committee review.

3.2 Outcomes of System-Wide Review
As part of the Statewide Transition Plan, the standards, rules, requirements, law, regulations, and policies listed in the narrative and chart below were assessed as they relate to the CS Waiver.
Based on feedback from CMS, SCDHHS reformatted the below information. The information and results have not changed, but the full analysis is now included indicating where our system, as it relates to the CS waiver, complies with or conflicts with the HCB setting requirements, the remediation needed, and the timeframe within which the remediation occurred or will occur. The charts give the overview of the HCBS system in South Carolina specific to the CS waiver, and the narrative below provides the details for any changes that need to take place as they relate to the CS Waiver.

3.2.1 Identified Laws/Regulations/Policies Found Not Compliant. With the first draft of the Statewide Transition Plan, SCDHHS identified the following areas as not being fully compliant with the Federal settings regulations as it relates to the CS waiver. Since that draft, SCDHHS has sought specific action to come into compliance with the HCBS regulations to remediate or ameliorate the below areas of concern.
1. SC Code Ann. § 44-20-420: “The director or his designee may designate the service or program in which a client is placed. The appropriate services and programs must be determined by the evaluation and assessment of the needs, interests, and goals of the client.”
a. This law is not compliant with 42 C.F.R. 441.301(c)(4)(iv). Having the director or his designee designate the services or program in which a client is placed does not optimize an individual’s initiative, autonomy, and independence in making life choices.
b. Ameliorated by SCDDSN Directive 567-01-DD (updated 7/2015) which includes language about person-centered approach to service planning, and ameliorated by SCDDSN Day Habilitation Standard #18 (updated 4/2016) which states, "Individuals receiving a DDSN Day Service are supported to make decisions and exercise choice regarding the specific DDSN Day services to be provided." Incorporating the person-centered service planning process ensures that individuals will make the choices for the services and supports they receive rather than having those choices made for them.
2. SC Code Ann. § 44-20-490: “When the department determines that a client may benefit from being placed in an employment situation, the department shall regulate the terms and conditions of employment, shall supervise persons with intellectual disability, a related disability, head injury, or spinal cord injury so employed, and may assist the client in the management of monies earned through employment to the end that the best interests of the client are served.”
a. This law is not compliant with 42 C.F.R. 441.301(c)(4)(iv). Having the director or his designee determine that a client may benefit from being placed in an employment situation, and then regulating the terms and conditions of that employment does not optimize an individual’s initiative, autonomy, and independence in making life choices.
b. Ameliorated by SCDDSN Directive 567-01-DD (updated 7/2015) which includes language about person-centered approach to service planning, and ameliorated by SCDDSN Day Habilitation Standard #18 (updated 4/2016) which states, "Individuals receiving a DDSN Day Service are supported to make decisions and exercise choice regarding the specific DDSN Day services to be provided." Incorporating the person-centered service planning process ensures that individuals will make the choices for the services and supports they receive rather than having those choices made for them.
c. Additionally, through CMS feedback, the concern was also raised that this statute may mean that “the state/provider must serve as the employer of record or supervisor of individuals in their employment situations.”
d. Currently, individuals served by SCDDSN have a variety of employment options which include, in some cases, where the provider is the employer of record, but many individuals also have fully integrated employment within the community with an employer who is not their service provider. Additionally, SCDDSN directive 510-01-DD Supervision of People Receiving Services states that, “People should live and work in the most natural and normal environments that support and respect their dignity and rights. Any support system that enables the person to be in those environments must be structured to manage the risks while facilitating self-determination, personal choice and responsibility […]. Supervision that is more restrictive than warranted is a violation of the person’s right to freedom of movement.” However, the State will seek to further define and explain the meaning of “supervision” as it applies to employment through sub-regulatory guidance which will clarify that individuals are not mandated to have the provider serve as their employer of record or supervisor. This will be accomplished by Jan. 31, 2017.
3. SCDDSN Directive 533-02-DD, Sexual Assault Prevention, and Incident Procedure Follow-up: “The family/guardians/family representative of both alleged perpetrator and victim should be notified of the incident as soon as possible by the Facility Administrator/Executive Director (or designee).”
a. This directive is not fully compliant with 42 C.F.R. 441.301(c)(4)(iii) and it is not fully compliant with 42 C.F.R. 441.301(c)(4)(iv). Mandating that a beneficiary’s family/guardians/family representative be notified if an incident occurs may violate a beneficiary’s right to privacy if that beneficiary does not want their family/guardian/family representative to be notified.

b. To be remediated by SCDDSN, and subject to approval by SCDHHS, by removing the above language and replacing it with

the following: "If the alleged perpetrator or the victim has a legal guardian, the legal guardian will be notified of the incident by the Facility Administrator/Executive Director (or designee) as soon as possible following the incident. If the alleged perpetrator and/or victim is an adult who does not have a legal guardian, with consent, those chosen by the service recipient to be informed of the incident will be notified by the Facility Administrator/Executive Director." This directive is currently under review with anticipated changes to be made by Dec. 31, 2016.

4. SCDHHS Policy: Leave of Absence from the State/CLTC Region of a Waiver Participant: "Individuals enrolled in Medicaid home and community-based waivers who travel out of state may retain a waiver slot under the following conditions: the trip out-of-state is a planned, temporary stay, not to exceed 90 consecutive days which is authorized prior to departure; the individual continues to receive a waiver service; waivered services are limited to the frequency of services currently approved in the participant's plan of service; waivered services must be rendered by South Carolina Medicaid providers; the individual must remain Medicaid eligible in the State of South Carolina."

SCDDSN Medicaid Waiver Policy Manuals Medicaid HCB Waiver Policy Regarding Waiver Services Provided while Clients Travel Out-of-State: "[…] Waiver participants may travel out of state and retain a waiver slot under the following conditions: the trip is planned and will not exceed 90 consecutive days; the participant continues to receive a waiver service consistent with SCDDSN policy; the waiver service received is provided by a South Carolina Medicaid provider; South Carolina Medicaid eligibility is maintained. During travel, waiver services will be limited to the frequency of service currently approved in the participant's plan. Services must be monitored according to SCDDSN policy. The parameters of this policy are established by SCDHHS for all HCB Waiver participants."

a. These policies do not specifically touch on any of the home and community-based settings requirements, but it may be an unnecessary restriction on waiver participants if they wanted to travel longer than 90 consecutive days. These policies may need further review.

b. The policy was reviewed and determined that it was an administrative requirement. Therefore, changes will not be sought to these policies.

Feedback from CMS on earlier versions of the systemic assessment resulted in some additionally raised concerns for the State to address.

• "The state found all of its day service setting standards to be fully compliant with 42 CFR 441.301(c)(4)(iv), which requires a setting to not regiment an individual's schedule and provide independence in life choices (p. 64). South Carolina's standards for Adult Activity Centers, Work Activity Centers, Sheltered Workshops, and "Unclassified" Day Programs, however, require staffing ratios – including administrative staff, not just direct support staff – of 7:1, 7:1, 10:1, and 10:1, respectively. These types of fixed staffing ratios raise concerns about whether a setting can support individualized activities and full access of individuals to the greater community. The standards also require the posting of program schedules at these facilities with defined start times, break times, and meals. Please describe within the STP how the state determined that these standards for a regimented schedule demonstrate full compliance with federal requirements or explain how these issues will be remediated."

o SCDHHS Response: The standards for the fixed staffing ratios and the posting of a program schedule are dictated by the SC Code of Regulations [SC Code of Regs 88-410 (B 1 a-d) and 88-435 (C 1-3)]. Because they are included in the regulation, they are included in the SCDDSN Standards for Licensing Day Facilities. These staffing requirements reflect the minimally required staffing ratios and in no way pose an absolute requirement. In an effort to support individualized activities and full access to the greater community, the SCDDSN Standards for Licensing Day Facilities provide guidance to explain the standard. The guidance instructs that SCDDSN Directive 510-01-DD entitled "Supervision of People" be used as the method through which the most appropriate level of supervision and support for the each person supported is to be determined, including each person's need for independent functioning. The guidance will be revised by December 2016.

o In an effort to support individualized activities and full access to the greater community, the SCDDSN Standards for Licensing Day Facilities provide guidance to explain the standard. For the requirement that program schedules be posted, the guidance instructs that the "schedules of activities should reflect the general schedule for the program. It is not necessary to specify the discrete activities that will occur with each service or program area. It is acceptable to identify the program start time, break times, lunch times, etc." The guidance was revised by December 2016.

3.2.2 Compliance by Settings Type. SCDHHS has created two crosswalks showing how HCB services are provided in compliance with the HCBS regulation by setting type for the CS Waiver. These two charts show how these settings are operated within South Carolina's system of governance of various health facilities and through the Medicaid program. This information reflects the information in the statewide transition plan. Each setting type has all of the laws, regulations, and policies that affect it within the one chart and with any noted required action to be taken if needed.

Day Care Setting

The information details the laws, regulations, and policies that are used to regulate an adult day health care center. This setting is utilized in South Carolina for individuals who need the specific service provided in the setting, regardless of payor source. Therefore, the experience of individuals receiving HCBS in this setting is consistent with how this setting would be experienced by individuals who are not HCBS service recipients.

HCBS Regulation: 42 CFR 441.301(c)(4)(i): The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community
Adult Day Health Care Centers: A person choosing to receive services in an Adult Day Health Care is choosing to participate in activities and therapies designed to activate, motivate and/or retrain participants to enable them to sustain or regain functional independence. Each facility has to make available social, group, individual, educational, recreational, and other activities. These activities take place in the facility, normally, but there must be opportunities for excursions or outings to points of interest of participants, assistance with community and personal referral activities, and planned indoor and outdoor recreation. Additionally, the setting is licensed the same as any other Adult Day Health Care facility in the state. S.C. Code. Regs. 61-75 (D).
Conflicting/Action Required: None
Timeline: N/A

HCBS Regulation: 42 CFR 441.301(c)(4)(i): include[es] opportunities to seek employment and work in competitive integrated settings
Adult Day Health Care Centers: The number of days a participant attends each week is determined through the Medicaid Home and Community-Based waiver service plan and indicated on the current service authorization. This plan is updated when a change needs to be made which would include adjustments for an individual seeking employment. See Scope of Services for ADHCs. SC Code of Regs. 61-75-501; “Each facility shall make available […] 4. Assistance with community and personal referral activities.”
Conflicting/Action Required: None
Timeline: None

HCBS Regulation: 42 CFR 441.301(c)(4)(i): engage in community life
Adult Day Health Care Centers: SC Code of Regs. 61-75-501; “Each facility shall make available […] 4. Assistance with community and personal referral activities. 6. Excursions or outings to points of interest; 7. Planned indoor and outdoor recreation.”
Conflicting/Action Required: None
Timeline: None

HCBS Regulation: 42 CFR 441.301(c)(4)(i): control personal resources
Adult Day Health Care Centers: Silent
Conflicting/Action Required: ADHC Scope of Service in Provider Contracts will be updated to include that “participants have the right to control their personal resources while under the care of the center.”
Timeline: 01/13/2017

HCBS Regulation: 42 CFR 441.301(c)(4)(i): receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS
Adult Day Health Care Centers: These settings are utilized in South Carolina for individuals who need the specific service provided in the setting, regardless of payor source. See SC Code Regs 61-75-101: (For adults 18 years of age or older, [with a] program directed toward providing community-based day care services for those adults in need of a supportive setting [.])
Conflicting/Action Required: SCDHHS will issue a policy statement to providers reinforcing that “the experience of individuals receiving Medicaid HCBS in non-residential settings should be consistent with how those settings would be experienced by individuals who are not Medicaid HCBS service recipients.”
Timeline: 1/1/2017

HCBS Regulation: 42 CFR 441.301(c)(4)(ii): The setting is selected by the individual from among setting options including non-disability specific settings [and] The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences[.]
Adult Day Health Care Centers: Beneficiaries have an array of services and supports to choose from and offered to them during the development of their person-centered service plan. Beneficiaries must be given freedom of choice when selecting services and providers which is documented in their Support plan. See CLTC provider manual Section 2 and See SCDDSN Case Management Standards.
Conflicting/Action Required: None
Timeline: None

HCBS Regulation: 42 CFR 441.301(c)(4)(iii): Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.
Adult Day Health Care Centers: S.C. Code Ann. 44-26-10 et. seq.:"Rights of Clients with Intellectual Disability"; S.C. Code Ann.43-35-5 et seq. "Adult Protections" A statement of Rights of Adult Day Care Participants must be posted in each facility. The rights, including but not limited to, privacy, dignity, respect, and the freedom from coercion and restrain can be found in

S.C. Code Regs. 61-75-901
Conflicting/Action Required: None
Timeline: None

HCBS Regulation: 42 CFR 441.301(c)(4)(iv): Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.
Adult Day Health Care Centers: S.C. Code. Regs. 61-75 -901(3): Individual have "The right to self-determination within the day care setting, including the opportunity to: a. Participate in developing one's plan for services and any changes therein. b. Decide whether or not to participate in any given activity. c. Be involved to the extent possible in program planning and operation. d. Refuse treatment, if applicable, and be informed of the consequences of such refusal. e. End participation in the adult day care center at any time."
Conflicting/Action Required: None
Timeline: None

HCBS Regulation: 42 CFR 441.301(c)(4)(v): Facilitates individual choice regarding services and supports, and who provides them.
Adult Day Health Care Centers: Beneficiaries are offered freedom of choice of providers within the geographic location in which they live. See CLTC provider manual Section 2 and See SCDDSN Case Management Standards
Conflicting/Action Required: None
Timeline: None

SCDDSN Operated Home and Community Based Settings – Day Services
The information below details the laws, regulations and policies that are used to regulate the SCDDSN-operated home and community based settings for the CS Waiver (i.e. Day services). This information reflects the information in the statewide transition plan. SCDHHS is presenting the information to show how the SCDDSN-operated settings are regulated systemically.

It is important to note that these laws, regulations, and policies apply to all non-residential settings operated by SCDDSN whether the individuals being served in that setting receives Medicaid HCBS. Therefore, the experience of individuals receiving HCBS in non-residential settings and residential are consistent with how those settings would be experienced by individuals who are not HCBS service recipients. See SC Code 44-20-20.

HCBS Regulation: 42 CFR 441.301(c)(4)(i): The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community
Supporting: SC Code Ann. 44-20-20 : It is the purpose of [all DDSN services] to assist persons with intellectual disability, related disabilities, head injuries, or spinal cord injuries by providing services to enable them to participate as valued members of their communities to the maximum extent practical and to live with their families or in family settings in the community in the least restrictive environment available.
Conflicting/Action Required: None
Timeline: None

HCBS Regulation: 42 CFR 441.301(c)(4)(i): include[es] opportunities to seek employment and work in competitive integrated settings
Supporting: SCDDSN Directive 700-07-DD "Employment Services- Individual, provided in integrated settings, is the first and preferred Day Service option to be offered to working age youth and adults [.]"
Conflicting/Action Required: None
Timeline: None

HCBS Regulation: 42 CFR 441.301(c)(4)(i): engage in community life
Supporting: SC Code Ann 44-26-90 . Rights of client not to be denied.
Unless a client has been adjudicated incompetent, he must not be denied the right to: (6) marry or divorce;
(7) be a qualified elector if otherwise qualified. The county board of voter registration in counties with department facilities reasonably shall assist clients who express a desire to vote to: (a) obtain voter registration forms, applications for absentee ballots, and absentee ballots;
(b) comply with other requirements which are prerequisite for voting;
(c) vote by absentee ballot if necessary;
(8) exercise rights of citizenship in the same manner as a person without intellectual disability or a related disability.
Conflicting/Action Required: None
Timeline: None

HCBS Regulation: 42 CFR 441.301(c)(4)(i): control personal resources
Supporting: SC Code Ann. 44-26-90 . Rights of client not to be denied.
Unless a client has been adjudicated incompetent, he must not be denied the right to:
(1) dispose of property, real and personal;
(2) execute instruments;
(3) make purchases;
(4) enter into contractual relationships
(5) hold a driver's license
SCDDSN Day Standard 14: “Individuals are expected to manage their own funds to the extent of their capability.”
Conflicting/Action Required: None
Timeline: None

HCBS Regulation: 42 CFR 441.301(c)(4)(i): receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.
Supporting: SCDDSN Day Services Standards (All services): Community Services provides individuals the opportunity to maximize their exposure, experience and participation within their local community. Through this process, the individual will gain access to inclusive citizenship and social capital.
Conflicting/Action Required: SCDHHS will issue a policy statement to providers reinforcing that “the experience of individuals receiving Medicaid HCBS in non-residential settings should be consistent with how those settings would be experienced by individuals who are not Medicaid HCBS service recipients.”
Timeline: 1/1/2017

HCBS Regulation: 42 CFR 441.301(c)(4)(ii): The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting.
Supporting: Beneficiaries have an array of services and supports to choose from and offered to them during the development of their person-centered service plan See SCDDSN Case Management Standards.
Conflicting/Action Required: State is currently receiving TA from CMS re: development of non-disability specific settings for these services.
Timeline: TBD

HCBS Regulation: 42 CFR 441.301(c)(4)(ii): The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.
Supporting: Beneficiaries must be given freedom of choice when selecting services and providers which is documented in their Support plan. See SCDDSN Case Management Standards

Conflicting/Action Required: None
Timeline: None

HCBS Regulation: 42 CFR 441.301(c)(4)(iii): Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.
Supporting: SECTION 44-26-160 . (A) No client residing in an intellectual disability facility may be subjected to chemical or mechanical restraint or a form of physical coercion or restraint unless the action is authorized in writing by an intellectual disability professional or attending physician as being required by the habilitation or medical needs of the client and it is the least restrictive alternative possible to meet the needs of the client.
(B) Each use of a restraint and justification for it must be entered into the client's record [.]
(C) No form of restraint may be used for the convenience of staff, as punishment, as a substitute for a habilitation program or in a manner that interferes with the client's habilitation program. […]
(F) The appropriate human rights committees must be notified of the use of emergency restraints.
(G) Documentation of less restrictive methods that have failed must be entered into the client's record when applicable.
SCDDSN Day Standard 13: "Individuals receiving a DDSN Day Service are free from abuse, neglect and exploitation."
SCDDSN Day Standard 14: “Each individual’s right to privacy, dignity and confidentiality in all aspects of life is recognized, respected and promoted. Personal freedoms are not restricted without due process.”
Conflicting/Action Required: SCDDSN Directive 600-05-DD and/or the SCDDSN Day Standards will be updated to include the freedom from coercion and restraint.
Timeline: 1/31/2017

HCBS Regulation: 42 CFR 441.301(c)(4)(iv): Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to

interact.
Supporting: SCDDSN Day Standard 18: "Individuals receiving DDSN Day Service are supported to make decisions and exercise choice regarding the specific DDSN Day services provided." - SCDDSN Day Services Standards
Conflicting/Action Required: SC Code Ann. § 44-20-420: “The director or his designee may designate the service or program in which a client is placed. The appropriate services and programs must be determined by the evaluation and assessment of the needs, interests, and goals of the client.” AND SC Code Ann. § 44-20-490: (A) When the department determines that a client may benefit from being placed in an employment situation, the department shall regulate the terms and conditions of employment, shall supervise persons with intellectual disability, a related disability, head injury, or spinal cord injury so employed, and may assist the client in the management of monies earned through employment to the end that the best interests of the client are served. Action Required: Remediate conflicting statutes through sub-policy guidance on person-centered service planning
Timeline: Completed 07/2015

HCBS Regulation: 42 CFR 441.301(c)(4)(v): Facilitates individual choice regarding services and supports, and who provides them.
Supporting: SCDDSN Day Standard 18: "Individuals receiving DDSN Day Service are supported to make decisions and exercise choice regarding the specific DDSN Day services provided." - SCDDSN Day Services Standards
Conflicting/Action Required: None
Timeline: None

3.3 Actions to Bring System into Compliance
For those policies, procedures, standards and directives that need modification as indicated in the previous section, SCDHHS will work with the appropriate internal staff and external agencies to make necessary changes. Small teams of key personnel began meeting in the fall of 2015 to review these policies and procedures to determine where changes needed to be made to bring waiver policies and procedures in line with the HCBS requirements.

The Division of Community Options at SCDHHS is responsible for the administration of the CS waiver program, and SCDDSN is responsible for the operation of the CS waiver. Community Options created a joint workgroup with SCDDSN that began in fall of 2015 to review SCDHHS and SCDDSN waiver specific policy, procedures, directives, and standards based on the outcomes of this assessment. Together they will make the necessary changes to waiver manuals, operating standards and corresponding directives, and quality indicators to bring waiver policy and procedures in line with the HCBS requirements. For the CS waiver renewal, those waiver renewal activities began in June 2016. SCDHHS presented the proposed CS renewal plan to the Medical Care Advisory Committee in November 2016 and plans to begin the first required Tribal Notification starting in December 2016. Changes to the waiver document to meet the HCBS standards will be included and once approved by CMS, the appropriate changes will be made to corresponding waiver policies and procedures. SCDHHS anticipates these changes to be completed no later than March 2018.

To ensure compliance overall with the settings requirements for the CS waiver they operate, SCDDSN will make any necessary changes to their standards and directives that relate to settings where waiver services are provided, including all Day Service standards documents as noted above. SCDDSN also uses a Quality Improvement Organization (QIO) to assess service providers for contract compliance and quality assurance. The key indicators utilized by the QIO that determine contract compliance and quality assurance for waiver service providers will be updated to reflect any changes made in the standards and directives. The RFP for the SCDDSN QIO provider will be posted in spring of 2017 and will be effective October 1, 2017. The RFP is reflective of the required use of the key indicators by the QIO to ensure compliance with SCDDSN policies, standards, and directives which will include HCB settings requirements.

3.4 Ongoing Compliance of System
Once system policies, procedures, standards, and directives have been updated to reflect the new HCBS requirements, ongoing compliance of the system will be monitored per the updated policies.

SCDHHS maintains a Memorandum of Agreement (MOA) with SCDDSN and is implementing an Administrative Contract as well to outline responsibilities regarding SCDDSN’s operations for the Community Supports (CS) waiver. The MOA requires SCDDSN to submit any policy, procedure, or directive changes that are related to waiver operations to SCDHHS for review and approval. This secondary review allows for ongoing monitoring of systemic HCBS compliance.
SCDHHS also uses a Quality Improvement Organization (QIO), an additional contracted entity, quality assurance staff, and other agency staff to continuously evaluate the operating agency’s (SCDDSN) quality management processes to ensure compliance. The QIO conducts validation reviews of a representative sample of initial level of care determinations performed by the operating agency (SCDDSN) as well as reviews all adverse level of care determinations. The additional contracted entity provides specific quality management tasks like provider agency operational audits. SCDHHS Quality Assurance (QA) staff

conduct periodic quality assurance reviews that focus on the CMS quality assurance indicators and performance measures. To ensure compliance of quality and general operating effectiveness, SCDHHS will conduct reviews of the operating agency (SCDDSN). SCDHHS also utilizes its Division of Program Integrity, who works cooperatively with QA and Waiver staff, to investigate complaints and allegations of suspected abuse or fraud that may impact the system. Program Integrity also maintains a good working relationship with the Medicaid Fraud Control Unit at the Attorney General's office to investigate suspected fraud or initiate criminal investigations. Statewide problems can be addressed through different measures, including revisions of policy and/or procedures. These processes allow the state to take the necessary action to ensure compliance with the new HCBS standards.

It is through these established systems of quality assurance review that ongoing compliance of HCBS standards will be monitored after the transition period ends on March 17, 2019.

4. Assessment of Settings

4.1 Setting Types
There are two primary settings where home and community-based services are provided in the CS waiver program, excluding private residences:
4.1.1 Day Services Facilities. There are approximately 83 Day Services Facilities most of which are licensed as an Adult Activity Center (AAC) and/or a Work Activity Center (WAC), an Unclassified Program and/or a Sheltered Workshop.
4.1.2 Adult Day Health Cares (ADHC). There are approximately 76 Adult Day Health Care settings utilized in the CS waiver.

4.2 Setting Assessment Process
The setting assessment process was divided into two separate assessment phases, a provider self-assessment phase and an independent site visit phase. Additionally, a survey for waiver participants and a survey for family members of waiver participants was created to solicit feedback on their experiences in the HCB settings that they or their family members use. They can be found at:
Beneficiary survey: https://msp.scdhhs.gov/hcbs/site-page/beneficiary-survey
Family survey: https://msp.scdhhs.gov/hcbs/site-page/family-survey

4.2.1 C4 Individual Facilities/Settings Self-Assessment. The C4 assessment was designed to evaluate individual facilities to determine compliance with the HCBS criteria outlined in 42 CFR 441.301(c)(4). This assessment tool was used for the providers' self-assessment and will be refined and revised for use on the independent site visits.
Providers self-assessed each of their individual non-residential settings. A self-assessment tool specific for non-residential settings was sent to every non-residential provider to complete on each of their non-residential settings. A copy of the non-residential provider self-assessment with instructions can be found in Appendix C of the Statewide Transition Plan.
The process of the self-assessments is described below.
Development of the assessment tools and criteria. An assessment tool was developed for non-residential facilities which includes all day services facilities licensed by SCDDSN and Adult Day Health Care Centers. The criteria used to create this tool is outlined in 42 CFR 441.301(c)(4). Additionally, SCDHHS used the exploratory questions issued by CMS for the settings requirements. The assessment tool was used by providers to complete the self-assessment of individual facilities. The setting-specific assessment was an online tool. For providers who did not have internet access, SCDHHS made available paper copies.
Resources to conduct assessments and site visits. Resources to conduct the assessments came from SCDHHS personnel and financial resources as well as individual provider personnel and financial resources.
SCDHHS sent electronic notification of the individual facility self-assessment process to providers in April 2015. Following the notification, the agency sent individual letters to providers with instructions on how to conduct the setting-specific assessments in May 2015. For providers who did not have internet access, paper copies of the assessment tools were made available to them. Individual letters were sent on May 15, 2015, to all HCBS non-residential providers with instructions on how to complete that self-assessment by July 1, 2015. All non-residential settings were assessed.
Any non-residential setting that self-identified through the initial C5 assessment or the C4 self-assessment as potentially being subject to the heightened scrutiny process will be subject to the Home and Community-Based Settings Quality Review process.
Timeframe to conduct assessments and site visits. Each part of the assessment process has an estimated time for completion. These time frames are based on personnel and financial resources and may vary.
Providers had 45 calendar days to complete and return the self-assessment for the non-residential settings they own and/or operate to SCDHHS. The deadline was established based on the letter's approximated day of delivery to providers.
Assessment review. SCDHHS individually reviewed all setting-specific self-assessments to determine each setting's status regarding HCBS compliance. Based on a review of the self-assessments, SCDHHS sent initial feedback to providers on their settings to help them get started on making any needed changes towards compliance prior to the independent site visits.
SCDHHS sent initial written feedback to Adult Day Health Care (ADHC) providers on their self-assessments on March 8, 2016.

Initial written feedback was sent to SCDDSN Day services providers with facilities on March 22, 2016.
4.2.2. C4 Individual Facilities/Settings Independent Site Visits. The C4 independent site visits are designed to evaluate individual facilities to determine compliance with the HCBS criteria outlined in 42 CFR 441.301(c)(4). These will be conducted after the self-assessments by providers are complete. The assessment tool that was used for the provider self-assessments will be refined and revised for use on the independent site visits. The independent site visits will be completed by the following entities:

- SCDHHS staff will conduct the site visits for the Adult Day Health Care facilities.
- A contracted vendor will conduct the site visits for all of the SCDDSN Day Services facilities.

The process of the site visits is described below.
Development of the assessment tools and criteria. Two assessment tools were developed based on the tools used for the provider self-assessments: one for Adult Day Health Care Centers and one for all day services facilities licensed by SCDDSN. The criteria used to create these tools is outlined in 42 CFR 441.301(c)(4). Additionally, SCDHHS used the exploratory questions issued by CMS for the settings requirements. SCDHHS will work with the contracted vendor to refine and finalize the assessment tools for the SCDDSN day services facilities.
Resources to conduct assessments and site visits. Resources to conduct the site visits for the Adult Day Health Care facilities came from SCDHHS personnel and financial resources. Resources to conduct the site visits for the SCDDSN day services facilities will come from SCDHHS personnel and financial resources in addition to the personnel and financial resources of a contracted vendor.
All non-residential, individual HCB settings will be subject to an independent site visit. They comprise approximately 76 Adult Day Health Care centers and approximately 83 discrete day services facility locations in which multiple non-residential settings may be located. Individual site visits will occur after the provider self-assessments.
The Adult Day Health Care facility site visits will be conducted by SCDHHS staff. These began in late January of 2016.
SCDDSN day services facilities will be subject to a site visit. SCDHHS will contract with an outside vendor to conduct site visits on 100 % of the discrete day services facility locations that are contracted with SCDDSN.
Timeframe to conduct assessments and site visits. Each part of the assessment process has an estimated time for completion. These time frames are based on personnel and financial resources and may vary.
Independent site visits of the Adult Day Health Care facilities are anticipated to take approximately 18 months to complete. This time frame began as SCDHHS started its site visits on ADHC settings in late January 2016. This extended deadline is due to a reevaluation of the time needed for the site visit, assessment and review process as well limited personnel resources.
To complete site visits on the SCDDSN Day Services facilities, SCDHHS solicited proposals from qualified entities to conduct those site visits. Site visits by a contracted vendor on SCDDSN Day Services facilities are anticipated to begin in January 2017 after a contract has been awarded to a qualified vendor. These site visits are anticipated to take approximately 9 months to complete.
Assessment review. SCDHHS will individually review all setting-specific assessments to determine if each setting is or is not in compliance. To determine the level of compliance or non-compliance, SCDHHS will use the data collected during both the provider self-assessment and the independent site visit assessment. Providers will receive final written feedback from SCDHHS on each setting after the independent site visits are completed and both assessments are reviewed.
The Adult Day Health Care settings review will be done by SCDHHS staff. The review will include the self-assessment of the facility, the independent site visit of the facility which includes feedback from individual participants on the facility and its program, the facility's policies, and any beneficiary or family member survey data from that facility (mentioned at the beginning of section 4.2). SCDHHS' goal is to complete the final assessment review of Adult Day Health Care settings no later than August 2017. This extended deadline is due to a reevaluation of the time needed for the site visit, assessment and review process as well limited personnel resources.
SCDHHS' goal to complete the final assessment review of SCDDSN day service facilities is within one month after the completion of those site visits which is anticipated to be November 2017. The review will be done by SCDHHS staff and SCDDSN staff. The review will include the self-assessment of the facility, the independent site visit of the facility which includes feedback from individual participants on the facility and its program, the facility's policies, and any beneficiary or family member survey data from that facility (mentioned at the beginning of section 4.2).
4.3 Outcomes
The outcomes of the setting assessment process is listed below by the provider self-assessment outcomes and the final HCBS compliance outcomes, determined after independent site visits and full reviews are completed.
As individual facilities are assessed and reviewed, SCDHHS will compile that data to submit to CMS. Upon completion, SCDHHS will be able to show what percentage of facilities, by type, meet the settings criteria and what percentage do not and will need to create a plan of compliance. The review for Adult Day Health Cares is anticipated to be completed by June 2017, with anticipated submission to CMS of an amended Statewide Transition Plan by the end of August 2017, after going through public notice and comment. The review for SCDDSN Day service providers is anticipated to be completed by October 2017 with anticipated submission to CMS in an amended Statewide Transition Plan by December 2017, after going through another public notice and comment period.
4.3.1 C4 Individual Facilities/Settings Self-Assessment Outcomes. There was 100% participation by providers in completing the Non-residential settings self-assessment.

To date, SCDHHS has gathered preliminary information from the Initial C5 Assessment (see Section 5.2) and the C4 provider self-assessment. Based on that information, SCDHHS estimates that the following number of settings fall into the following categories.

Non-residential Settings

HCBS Compliance Category
Fully comply with federal requirements
ADHC: 0
AAC: 0
WAC: 0
Unclassified: 0
Do not comply – will require modifications
ADHC: 0
AAC: 0
WAC: 0
Unclassified: 0
Cannot meet requirements – will require removal from the program/relocation of individuals
ADHC: 2
AAC: 0
WAC: 0
Unclassified: 0
Subject to State Review for possible Heightened Scrutiny Review by CMS
ADHC: 74
AAC: 52
WAC: 30
Unclassified: 28

As indicated above, SCDHHS is subjecting all non-residential facilities to state review for possible Heightened Scrutiny review by CMS (the HCB Settings Quality Review process, see Section 5). The data above will likely change once the independent site visits are completed on the settings and a full review is completed for each individual setting.

4.3.2. Final HCBS Compliance determination. The final level of HCBS compliance of individual settings will be determined after independent site visits and full reviews are completed. SCDHHS will develop an individualized response by provider for each facility based upon the self-assessment and site visit. The agency will leverage responses from the self-assessment and site visit to identify gaps in compliance, as well as include any global policy or programmatic changes that are necessary for the provider to comport with the new HCBS standards as detailed in the “Assessment Review” section, 4.2.2, above. SCDHHS will develop these responses as site visits are completed.
To date, 24 Adult Day Health Care facility site visits have been completed, but have not undergone a full review. Those full reviews will be completed and responses went out in December of 2016. Once those responses are sent out, SCDHHS will continue with the ADHC site visits.
The SCDDSN day services facilities will not have a final HCBS compliance determination made until the independent site visits are completed and a full review is done on each of those settings.

4.4 Actions for Facilities Deemed not in Compliance
Based on the outcome of the full review, providers must create a compliance action plan for their facility(ies) and indicate how they will bring it(them) into compliance with the requirements. The action plan must include a timeframe for completion and be submitted to SCDHHS for approval within 30 days of receiving the written notice. Compliance Action Plans for Adult Day Health Care facilities will be reviewed by SCDHHS staff. Compliance Action Plans for SCDDSN day services facilities will be reviewed by SCDHHS staff and SCDDSN staff. Each action plan will be reviewed to determine if the action plan is approved or needs revision. SCDHHS will send providers a letter indicating whether their action plan is approved and they can move forward with their changes, or whether the action plan needs further work. If the action plan needs further work, SCDHHS will give providers two weeks from receipt of the letter to make changes to the action plan and resubmit it to SCDHHS for approval. SCDHHS, and SCDDSN where appropriate, will review the revised action plan and will either approve it, or send notification to the appropriate program area to have the provider and setting reviewed for disciplinary action.
In addition to participating in the compliance action plan review process, SCDHHS will include the appropriate SCDHHS program area and/or SCDDSN on communication sent to providers at every step of the settings assessment process. SCDHHS will submit copies of the following to the appropriate SCDHHS program area and/or SCDDSN:
- Each provider’s initial response letter to their self-assessment

- Each provider's final, individualized response letter
- SCDHHS' response to each provider's initial submission of a compliance action plan (whether it is approved or needs revision), along with a copy of the provider's initial action plan
- SCDHHS' response to providers who had to submit a revised action plan (whether it is approved or will be sent to program area for disciplinary action review), along with a copy of the provider's revised action plan
- A copy of a provider's approved action plan

This will allow the appropriate SCDHHS program area and/or SCDDSN to monitor progress toward compliance and continued monitoring of compliance through established quality assurance and/or licensing protocols. Those protocols are detailed in the "Ongoing Compliance" section.

SCDHHS or a contracted vendor will conduct follow-up site visits to monitor the progress of those providers who must come into compliance, in accordance with their approved compliance action plans. These visits will occur after a facility's action plan has been approved by SCDHHS, but before the March 2019 compliance deadline. The appropriate SCDHHS program area and/or SCDDSN will receive the results of those follow-up site visits to assist them in monitoring the progress of their providers of becoming compliant with HCB standards.

CMS provided feedback to SCDHHS about "reverse integration" as a strategy for access and integration compliance, indicating it cannot be the only method providers use to meet access and integration compliance. To address this issue, SCDHHS will provide and share technical assistance with providers to help settings ensure they facilitate full access and integration for waiver participants into their community. This will include informal information sharing as site visits are conducted or informal meetings with providers are held, presentations done at provider association meetings, resources sent to providers, program areas and other state agencies, and formal feedback through individual responses to completed site visits to assist in this transition period. As mentioned in the "Actions to Bring System into Compliance" section (Section 3.3), the assessment tool utilized for the ADHC site visits will be incorporated into the provider reviews that are conducted at least every 18-24 months by SCDHHS staff. This tool will cover the settings requirements detailed in 42 CFR 441.301(c)(4) as it relates to non-residential settings and will help measure compliance of settings providing access and integration for waiver participants into their community.

SCDDSN, as noted in Section 4.5, plans to incorporate elements of the non-residential assessment tool used in the independent site visits into their provider assessment so that the new HCBS requirements detailed in 42 CFR 441.301(c)(4) are captured as part of the regular review process by the QIO.

4.4.1 Relocation of Waiver participants. Relocation of waiver participants may be needed due to a setting's inability to come into compliance with the new standards, or a setting is deemed by CMS through the heightened scrutiny process to not be home and community-based. SCDHHS will utilize the following procedures to transition participants in those settings to an appropriate setting. Each participant will have an individualized transition plan that is designed to meet their needs. These procedures may change to best meet the needs of the waiver participants.

Relocation of waiver participants in non-compliant Adult Day Health Care settings. SCDHHS would identify all participants authorized to receive services from the provider of the non-compliant setting. The appropriate area offices and/or agencies would be notified of the status of the setting as non-compliant. Additionally, the participants' case managers would be informed of the status of the setting as non-compliant so that they could reach out to their participants to inform them of the setting's status change. Case managers would provide the participants with a list of other available, compliant providers from which they can choose. Once a participant chooses a provider, the case manager can then make a referral and process an authorization for that participant for the new provider.

If the participant chooses not to use another provider, the case manager may explain alternative options should the waiver participant choose to still receive services from the non-compliant provider setting. If there is no other viable provider, the case manager may work to authorize other services to substitute for the service change. The case manager would then monitor the participant to ensure that the new service package is meeting the participant's needs in accordance with the person-centered plan.

As noted in the table above, there are two adult day health care settings that cannot meet HCBS standards as they are located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment. The number of waiver participants currently receiving services in those settings is 19 total. At this time, these are the only two settings believed to not be home and community based that will require relocation of waiver participants. Relocation of these waiver participants will not begin until after a site visit is completed on each site.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

South Carolina Department of Health and Human Services
Community Supports (CS) Waiver
Transition Plan
December 2016 (Con't)

Relocation of waiver participants in non-compliant SCDDSN Day services settings. SCDDSN would identify all participants authorized to receive services from the provider of the non-compliant setting. The appropriate district offices and/or agencies would be notified by SCDHHS of the status of the setting as non-compliant. Additionally, the participants' case managers would be informed of the status of the setting as non-compliant so that they could reach out to their participants to inform them of the setting's status change. The appropriate District Office would facilitate the relocation of participants with the case managers and any other appropriate personnel, providing the participants with a list of other available, compliant providers from which they can choose. Once a participant chooses a provider, the case manager can then make a referral and process an authorization for that participant for the new provider. SCDDSN will keep SCDHHS informed of all waiver participant relocations.
If the participant chooses not to use another provider, the case manager may explain alternative options should the waiver participant choose to still receive services from the non-compliant provider setting. If there is no other viable provider, the case manager may work to authorize other services to substitute for the service change. The case manager would then monitor the participant to ensure that the new service is meeting the participant's needs in accordance with the person-centered plan.
Timeline. Relocation of waiver participants would be made after:

- SCDHHS has determined the setting to be institutional and can no longer provide HCB services, or
- CMS has determined after a heightened scrutiny review that the setting is institutional and can no longer provide HCB services.

This process of relocation is anticipated to begin in mid-to-late 2017 as SCDHHS anticipates it will have concluded its independent site visits for Adult Day Health Cares by the end of June 2017. Those relocations are anticipated to be completed by the end of the 2017 calendar year. For waiver participants in SCDDSN Day service provider locations that may be non-compliant, those relocations will begin later in 2017 at the conclusion of those site visits and should be completed by December 2018.
For waiver participants who choose to be relocated from either a non-compliant Adult Day Health Care or Day service setting, they will be given 30 days' notice that they will need to move to a new, compliant setting. This notice is intended to minimize disruption of services for the waiver participant. Additionally, each participant's case manager will ensure an individualized approach for transitioning each waiver participant from non-compliant settings.

4.4.2 Non-disability specific settings. SCDHHS will utilize technical assistance provided and conduct research on other states that have implemented the use of non-disability specific settings to explore what could be learned and adapted for South Carolina. SCDHHS will also explore potential relationships with existing local resources to see how they can be utilized to provide home and community-based services to waiver participants in a setting that is non-disability specific.

4.4.3 Individual private homes. Individuals not living in provider owned or controlled homes deserve the same access and integration to their community as individuals not receiving HCB services. To ensure that these individuals are not isolated in their communities in which they choose to live, SCDHHS must confirm that individual private homes were not established or purchased in a manner that isolates them from their community. The Community Options Division of SCDHHS will discuss with SCDDSN appropriate ways to gather this information through the regular case manager face-to-face visits or annual re-evaluation assessments of the waiver participant. After policy and process revisions and any staff and/or provider training, a process will be determined and implemented by July 1, 2017.

4.5 Ongoing Compliance
Ongoing compliance of settings is currently monitored through SCDHHS policies and procedures as well as SCDDSN policies, procedures, standards and directives. There are established compliance systems in place at the agencies that monitor providers and their services to ensure they are compliant in providing the waiver services as stated in their contracts/enrollment agreements which are in line with the CS waiver document. It is through these established systems, which are described below, that ongoing compliance of the settings with the new HCBS requirements will be monitored. As mentioned in the "Ongoing Compliance of the System" section of this document, the policies, procedures, standards and directives that direct the current compliance systems will be updated to reflect the new HCBS requirements to ensure the ongoing compliance of the settings.

4.5.1. Ongoing Compliance – Adult Day Health Care settings. While Community Supports waiver participants are served through SCDDSN providers, the Community Long Term Care (CLTC) division of SCDHHS holds the contracts with Adult Day Health Care settings and therefore has the responsibility for monitoring ongoing compliance of these settings.
The Community Long Term Care (CLTC) division of SCDHHS has waiver review as part of the overall CLTC Quality Assurance (QA) Plan. This includes review of Adult Day Health Care settings that provide home and community-based services. Information is gathered and compiled from many data sources including Provider Compliance Reports from SCDHHS staff;

APS/critical incident reports; and provider reviews conducted at least every 24 months by SCDHHS staff (which includes reviews of ADHC's).
As part of the CLTC QA Plan, information gathered is taken to the Quality Improvement Task Force, which is scheduled to meet bi-monthly. Data is reviewed and discussed for discovery of noncompliance and strategies for remediation. Reports and trends are shared with area offices and providers as appropriate. Anything requiring corrective action generates a report and request for corrective action plan to the area office administrator. This includes corrective action for ADHC's. All reports, corrective action plans, appeals and dispositions are brought to the Quality Improvement Task Force to review outcomes. Outcomes would assist in determining necessary policy or system changes. This process allows a thorough assessment of areas needing improvement and areas of best practice.
As mentioned in the "Actions to Bring System into Compliance" section, the assessment tool utilized for the ADHC site visits will be incorporated into the provider reviews that are conducted at least every 18-24 months by SCDHHS staff. This tool will cover the settings requirements detailed in 42 CFR 441.301(c)(4) as it relates to non-residential settings.
Ongoing monitoring and compliance of ADHCs will be conducted in two ways: by a designated staff member of CLTC to conduct on-site reviews and by a contracted vendor to collect participant feedback on their specific ADHC program. The reviews will begin 18-24 months after the initial assessment and compliance action period and will consist of an onsite visit to each facility to observe settings and participants' individual integration into the community. The staff member will utilize a questionnaire (to be completed by December 2017) that contains the same components of the initial assessment to complete the on-site reviews. The contracted vendor will also utilize a questionnaire that contains the same components of the initial assessment to collect participant feedback via telephone surveys. Currently, the State has a sanctioning policy ranging from corrective action plans up to termination and the State anticipates utilizing the same sanctioning policy to address noncompliance with the HCBS regulatory requirements. Tracking of compliance results will be stored in CLTC's Phoenix system for easy reporting.
In June 2017, CLTC will host a provider training to address recent changes to service provision related to HCBS requirements. Providers will receive an in-depth training on the regulations and ongoing expectations of reviews. The State will host additional trainings for providers as requested. Staff members of CLTC have received and will continue to participate in in-depth training from CMS on HCBS requirements. Any new employees will receive training from knowledgeable staff members on the HCBS requirements.
It is through this established system of quality assurance review, provider compliance, and staff and provider training that ADHC settings' ongoing compliance of HCBS standards will be monitored.

4.5.2. Ongoing Compliance – SCDDSN Day services facilities. SCDHHS maintains a Memorandum of Agreement (MOA) with SCDDSN and has a service contract with SCDDSN that outline the provider responsibilities for the Community Supports (CS) waiver. Additionally, SCDHHS is implementing an Administrative Contract to outline responsibilities regarding SCDDSN's waiver operations for the CS waiver. As mentioned in the "Actions to Bring System into Compliance" section, the Community Options Division of SCDHHS created a joint workgroup with SCDDSN that began in fall of 2015 to revise SCDHHS and SCDDSN waiver specific policy, procedures, directives, and standards including those related to compliance of providers and settings. The specific CS renewal activities began in June of 2016. Together they will make the necessary changes to waiver manuals, operating standards and corresponding directives, and key indicators to bring waiver policy and procedures in line with the HCBS requirements to ensure ongoing compliance of settings.
SCDHHS uses a Quality Improvement Organization (QIO), an additional contracted entity, quality assurance staff, and other agency staff to continuously evaluate the operating agency's (SCDDSN) quality management processes to ensure compliance. The QIO conducts validation reviews of a representative sample of initial level of care determinations performed by the operating agency (SCDDSN) and all adverse level of care determinations for all waivers operated by SCDDSN. The additional contracted entity provides specific quality management tasks like provider agency operational audits. SCDHHS Quality Assurance (QA) staff review all critical incident reports, ANE reports, results of QIO provider reviews, and receive licensing/certification reviews upon completion and any received participant complaints. SCDHHS QA staff conduct periodic quality assurance reviews that focus on the CMS quality assurance indicators, performance measures, financial expenditures, and appropriateness of services based on assessed needs. In addition, SCDHHS QA staff perform look-behind reviews of the SCDDSN QIO reports to ensure appropriateness of findings and the return of Federal Financial Participation (FFP) as warranted. SCDHHS QA staff also utilize other systems such as Medicaid Management Information Systems (MMIS) and Truven Analytics Healthcare to monitor quality and compliance with waiver standards. SCDHHS also utilizes its Division of Program Integrity, who works cooperatively with QA and Waiver staff, to investigate complaints and allegations of suspected abuse or fraud that may impact the system. Program Integrity also maintains a good working relationship with the Medicaid Fraud Control Unit at the Attorney General's office to investigate suspected fraud or initiate criminal investigations. To ensure compliance of quality and general operating effectiveness, SCDHHS will conduct a review of the Operating Agency (SCDDSN).

SCDDSN contracts with an independent Quality Improvement Organization (QIO) to conduct assessments of service providers by making on-site visits as a part of its quality assurance process. Providers are reviewed at least annually to every 18 months. This includes on-site visits to Day (non-residential) settings. During these visits, records are reviewed, participants and staff are

interviewed, and observations made to ensure that services are being implemented as planned and based on the participant's need, and that they comply with contract and/or funding requirements and best practices. SCDDSN plans to incorporate elements of the non-residential assessment tool used in the independent site visits into their provider assessment so that the new HCBS requirements are captured as part of this regular review process by the QIO.
SCDDSN also utilizes the independent QIO to complete annual Licensing Inspections for all Day Programs contracted for operation by the agency. Many of the current licensing standards for SCDDSN include the HCBS settings requirements. Other HCBS requirements for settings will be included in the quality assurance process as noted above.
As a policy and resource to provider agencies, SCDDSN has developed an Agency Directive 567-01-DD to address Employee Orientation, Pre-service and Annual Training Requirements. This directive covers all staff in provider organizations and ensures the philosophy and practical application of HCBS principles are present at each service location. Compliance with this directive is measured by the independent QIO through SCDDSN's Contract Compliance Review Process.
SCDDSN recognizes that the quality of the services provided is dependent upon well-trained staff. It is the intent of this directive to establish the required minimum level of staff competency so that those who support individuals with disabilities acquire the knowledge, skills and sensitivity to meet the needs of those individuals, consistent with the mission and vision of SCDDSN. SCDDSN has included requirements for person-centered, community based services within the context of various training modules and on-going training and technical assistance available to provider agencies.
Staff whose job descriptions indicate the duty of working directly with individuals who receive services shall be trained according to the minimum requirements set forth in the Directive. Competency will be demonstrated by a combination of written tests and skills checks. All staff are also required to receive a minimum of an additional ten (10) hours of job-related training annually, which will continue to focus quality service delivery. Professional staff meetings, workshops and conferences related to job functions may be considered in meeting this requirement.
As mentioned above, providers of HCB Services will be subject to Contract Compliance Reviews and Licensing Reviews by SCDDSN's contracted QIO. Employee training is a specific component within the Provider agency's Administrative Review. Key Indicators target training for Day Service staff. As a quality improvement strategy, SCDDSN has developed a checklist for providers to use to ensure staff training requirements for new employees and for annual/ on-going training. In addition, provider funding may be recouped if the employees do not meet minimum training requirements.
SCDDSN monitors the results of the QIO's reports as they are completed (approximately 30 days after the review date) to monitor overall compliance with quality assurance measures and to ensure appropriate remediation. Any deficiencies found with the provider's compliance will require a written Plan of Correction that addresses the deficiency both individually and systemically. This includes any deficiencies related to the new HCBS standards. A follow-up review will be conducted approximately 6 to 8 months after the original review to ensure successful remediation and implementation of the plan of correction. SCDHHS reviews the submitted results of DDSN QIO quality assurance review activities throughout the year. SCDDSN also monitors the QIO reports of findings to identify larger system-wide issues that require training and/or technical assistance. The additional review is also completed in an effort to analyze trends that require remediation in policy or standards. Any issues noted are communicated through the provider network in an effort to provide corrective action and reduce overall citations. These issues are addressed through periodic counterpart meetings with SCDDSN personnel and representatives of Provider Associations. After much collaboration and the opportunity for public comment, policy revisions are implemented as needed. Current and proposed SCDDSN Directives and Standards are available to the public for review at any time on the SCDDSN Web-site at www.ddsn.sc.gov/aboutddsn.

It is through the SCDHHS QA process, SCDDSN service provider assessment process and the annual licensing inspection process that day facilities ongoing compliance with HCBS standards will be monitored.

5. Heightened Scrutiny

Heightened scrutiny is the process of identifying settings that are presumed to have the characteristics of an institution and therefore are subject to more intense review (scrutiny) by the state. Using the criteria in 42 CFR 441.301(c)(5), SCDHHS will gather data on settings to determine whether the settings have home and community-based qualities. SCDHHS named this process the "HCB Settings Quality Review." After completing this review, the state will then determine if any of the settings will be submitted to CMS for final heightened scrutiny review.

5.1 HCB Settings Quality Review Process
SCDHHS has undertaken the following actions to identify settings that may need to go through the HCB Settings Quality Review process:
- Initial C5 Heightened Scrutiny Assessment
- C4 Individual Facilities/Settings Self-Assessment
- Geocode Data generation
- Public Input

The criteria that SCDHHS will use to determine which settings will be subject to the settings quality review includes the following:

- Does the setting have institutional characteristics as defined in 42 CFR 441.301(c)(5)(v)?
- Are there geographic location concerns that indicate potential clustering of settings or isolation from the community?
- Are there programmatic characteristics of settings that may have the effect of isolating individuals?
- Outcomes of the four (4) processes listed above

5.2 Initial C5 Heightened Scrutiny Assessment

This assessment was designed to gather initial data to assist SCDHHS in determining if any settings might be subject to the heightened scrutiny process detailed in 42 CFR 441.301(c)(5)(v). Providers self-reported if any of the settings they own or operate have the following qualities:

- Are located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment;
- Are in a building on the grounds of, or immediately adjacent to, a public institution;
- Has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS.

5.2.1 Development of the assessment tool and criteria. The assessment tool questions utilized the criteria directly from 42 CFR 441.301(c)(5). Providers listed the physical addresses of each facility they own/operate and answered a questionnaire to see if they would be subjected to heightened scrutiny. A letter with directions on how to complete the online assessment was mailed to providers. Providers were directed to review the CMS technical guidance on settings that have an effect of isolating individuals to assist in their answers to the assessment.

5.2.2 Resources to conduct assessments. Resources to conduct the assessments came from SCDHHS personnel and financial resources as well as individual provider personnel and financial resources.

5.2.3 Timeframe to conduct assessments. The “C5” (heightened scrutiny) assessment was mailed out the week of Nov. 3, 2014. Providers only completed one assessment to list each facility they own/operate. Providers had until Dec. 1, 2014, to complete the “C5” assessment and return it to SCDHHS. That was approximately 26 calendar days.

5.2.4 Assessment review. SCDHHS reviewed the initial data gathered from the “C5” assessments to prioritize site visits for any provider who self-reported that they may need to go through the formal heightened scrutiny process (SCDHHS HCB Settings Quality Review). Aggregate data results are provided in Outcomes section below.

5.2.5 Outcomes. Providers completed the “C5” assessment based on their own interpretation of the regulations and materials provided by CMS on the settings that have the effect of isolating individuals. Actual compliance or non-compliance with 42 C.F.R. 441.301(c)(5) will be determined by SCDHHS or CMS.

Initial C5 Initial Assessment Results

ADHC: 43 assessed; 4 may be subject to C5 process
AAC: 55 assessed; 9 may be subject to C5 process
WAC: 32 assessed; 3 may be subject to C5 process
Workshop: 6 assessed; 2 may be subject to C5 process

- Provider Response: 67.46%
- Total Providers: 126
- Providers who responded: 85
- Providers who did not respond: 41

Note – these numbers reflect providers of non-residential and residential settings as indicated in the Statewide Transition Plan.

Although there was not 100% provider participation in completing the Initial C5 Heightened Scrutiny Assessment, the same questions were included as part of the C4 Individual Facilities/Settings Assessment in which there was 100% provider participation.

5.3 C4 Individual Facilities/Settings Self-Assessment

This self-assessment asked providers a series of questions that looked at the physical qualities of the setting and programmatic qualities of the setting. This was for all non-residential settings. The details of this self-assessment process are in Section 4.2.1. The assessments can be found in Appendix C of the Statewide Transition Plan.

The results of the self-assessment that indicate physical or programmatic characteristics that may isolate waiver participants were used to determine if the setting should be placed under the HCB Settings Quality Review process. These identified settings will go through the HCB Settings Quality Review process that will take place concurrently with the independent site visits.

5.4 Geocode Data generation

SCDHHS had the Division of Medicaid Policy Research in the Institute of Families and Society at the University of South

Carolina complete a geocode analysis of the physical locations of all HCB settings within South Carolina. This data has broken down the proximity of each setting to public and private institutions and other HCB settings. It shows generally where HCB settings are located in comparison to the broader community of each town. The information gathered from this project will be used to determine if there are geographic location concerns that indicate potential clustering of settings or isolation from the community. These settings will be included in the HCB Settings Quality Review.

5.5 Public Input
SCDHHS sought public input in the fall of 2015 on settings that might be subject to the heightened scrutiny process. Public notice was sent out on October 30, 2015 informing the public about SCDHHS HCB Settings Quality Review process. The public comment period was from November 2, 2015, to December 31, 2015. The public notice was communicated in the following ways:
- Posted on the SCDHHS HCBS website: https://msp.scdhhs.gov/hcbs/site-page/hcb-settings-quality-review
- Posted on the SCDHHS website: https://www.scdhhs.gov/public-notice/home-and-community-based-services-hcbs-final-rule-heightened-study-scdhhs-seeks
- Email sent via the SCDHHS listserv on November 3, 2015
- Individual emails sent to the HCBS Workgroup, providers, advocate groups, and other stakeholders on November 3, 2015

Additionally, a live webinar was held on November 18, 2015, to explain to the public what SCDHHS was looking for in this public input process. The webinar was recorded and made available for viewing, along with a transcript of the recording, on the Family Connection of SC website: http://www.familyconnectionsc.org/webinars

Information provided through this public input was reviewed for inclusion on the independent site visits that will occur beginning in 2016.

5.6 HCB Settings Quality Review Next Steps
5.6.1. HCB Settings Quality Review – Criteria. SCDHHS is using all of the above information to inform which settings will need to go through the HCB Settings Quality Review. After individual non-residential settings have been identified to be included in the HCB Settings Quality Review process, they will be instructed to submit the following evidence to SCDHHS for review:
- License from applicable licensing agency
- Zoning information of surrounding area
- Description of how the program or setting helps individuals access community settings used by individuals not receiving Medicaid waiver services
- Documentation of training for staff employed in the setting that indicate training or certification in home and community-based services
- Documentation of training for staff employed in the setting that indicate training or certification in person-centered thinking and/or planning
- Documentation of how individuals' schedules are varied according to the typical flow of the local community (appropriate for weather, holidays, sports seasons, faith-based observation, cultural celebrations, employment, etc.)
- Description of the proximity to avenues of available public transportation or an explanation of how transportation is provided where public transportation is limited
- Pictures of the site and other demonstrable evidence (taking in consideration the individual's right to privacy)
- Any other evidence the provider thinks will show the setting is integrated in the community to the extent that a person or persons without disabilities in the same community would consider it a part of their community and would not associate the setting with the provision of services to persons with disabilities.

5.6.2 Site visits. One part of the review process consists of a site visit to the setting under review utilizing the refined and revised C4 settings assessment. Interviews with waiver participants who utilize the setting will also be conducted. Additionally, SCDHHS will ask the provider of the setting to produce evidence that the setting does not have institutional qualities and either does meet or could meet, with corrective action, the HCB settings requirements. The evidence is outlined above and detailed at https://msp.scdhhs.gov/hcbs/site-page/hcb-settings-review.
5.6.3 Heightened Scrutiny Determination. Once the site visits are completed and all documentation, evidence and other data gathered are reviewed, SCDHHS will review all of the provided information to determine if the setting is one of the following:
1. Institutional and can no longer provide HCB services. This setting will not be sent to CMS for heightened scrutiny review.
2. Is not institutional and is home and community-based. This setting may need some corrective action to be fully compliant, but will go through the transition period.
3. Is presumed institutional, but is home and community based and will therefore be sent to CMS for final Heightened Scrutiny review.

For any setting that SCDHHS determines is subject to heightened scrutiny by CMS, SCDHHS will request that the provider produce evidence (if they have not already done so) that the setting does not have institutional qualities and does meet the HCB settings requirements. If the setting is home and community-based but requires some compliance action before it fully meets the HCB requirements, SCDHHS will work with the provider of that setting to ensure that corrective action is taken to meet the

HCB requirements before submitting the setting to CMS for final Heightened Scrutiny review. The evidence will be reviewed by SCDHHS and may be made available for public comment.

Once SCDHHS has made its heightened scrutiny determinations, it will solicit an outside review of those determinations by advocacy groups. They will be provided with the regulatory language, applicable CMS guidance, information on the HCB Settings Quality Review process, and all documentation for each setting to evaluate SCDHHS findings. That feedback will be utilized to further refine SCDHHS heightened scrutiny submission to CMS.

5.6.4 Public notice and comment. After the determinations are made, SCDHHS will publish a list of settings it has identified as presumed institutional, but is a home and community-based setting, for public review and comment in the amended Statewide Transition Plan that will be submitted to CMS per CMS guidance. SCDHHS anticipates submission of a heightened scrutiny list of any Adult Day Health Care (ADHC) settings to CMS for review by October 27, 2017. The heightened scrutiny list of any Day Services facilities is anticipated to be submitted to CMS by December 29, 2017. SCDHHS will solicit comments from the public, including beneficiaries and/or personal representatives of beneficiaries, as to the qualities of each of these settings. The public will be able to suggest the addition of any setting to the list if a member of the public determines it may meet the definition of a setting that has institutional qualities that isolate individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS. SCDHHS will conduct a site visit on any setting that is on the list. SCDHHS will take public comment under consideration, but ultimately any determination as to what settings SCDHHS will submit to CMS for its review, what settings will not need to be submitted to CMS for review, and what settings will no longer be able to provide HCBS after March 17, 2019, will be made by SCDHHS.

5.6.5 Submission to CMS for Heightened Scrutiny Review. After the public notice and comment period on the Statewide Transition Plan with the included list of settings subject to heightened scrutiny, SCDHHS will submit a final list of settings for CMS Heightened Scrutiny Review.

For any setting that is not home and community-based and remedial actions are not sufficient enough to make the setting compliant with the home and community-based regulations, appropriate action will be taken by SCDHHS to insure continuity of care for any current waiver participants' receiving home and community-based services in this setting. Procedures for participant relocation will be followed as outlined in the "Relocation of Waiver participants" section above.

PUBLIC SUMMARY

Summary of the Public Meetings and Comments for the Renewal of the Medicaid Community Supports Waiver Program and the Community Supports Waiver Transition Plan.

The South Carolina Department of Health and Human Services (SCDHHS) held public webinar on the DHHS website (December 22, 2016) and one public meeting in Columbia, SC (January 5,2017).

The meetings provided information about the Agency's intent to request a five-year renewal of the Community Supports (CS) home and community-based waiver program, the CS Waiver Transition plan and allowed an opportunity for the public to comment. The public was provided the proposed information prior to the meetings, and the proposed CS Waiver Transition Plan was posted online for public viewing and comment. Copies of the proposed waiver renewal document, including the CS Waiver transition plan, were made available for public review at the following locations and websites:

SCDHHS front lobby at 1801 Main Street, Columbia, S.C.
All 13 DHHS/CLTC Regional Offices
SCDHHS website: https://www.scdhhs.gov/public-notices
South Carolina Department of Disabilities and Special Needs website: www.ddsn.sc.gov
Family Connections SC website: www.familyconnectionsc.org
South Carolina Developmental Disabilities Council website: www.scddc.state.sc.us

The public was also provided the opportunity to submit comments through the mail at SCDHHS Division of Community Options P.O. Box 8206 Columbia, S.C. 29202-8206,
and electronically to comments@scdhhs.gov. A summary of those comments are as follows:

Summary of Public Comments and the SCDHHS Response to the
2017 Community Supports (CS) Waiver Renewal and Transition Plan

Services

- A commenter indicated she was told that pest control would be added to the CS Waiver and questioned why this service is not included.

SCDHHS Response: Prior to the Renewal process, the State contracted for a CS Waiver Client Satisfaction Survey and pest control was not requested. Likewise, DDSN did not recommend this service addition.

- A commenter questioned if participants/families were asked what services were useful/needed and/or which services weren't.

SCDHHS Response: Aside from the Client Satisfaction Survey, the State received no input for service package changes and concluded new services were not appropriate at this time. The State did identify the need to expand provider access for in-home respite, and it is included as part of the renewal proposal.

Eligibility

- A commenter asked what happens to individuals on the waiting list now who don't have Medicaid.

SCDHHS Response: Waiver participants must have Medicaid Eligibility to enroll in a home and community-based waiver. For this reason, applicants who are serious about receiving waiver services should already have, or be in the process of making an application for Medicaid eligibility.

- A commenter indicated some clients have Medicaid Eligibility but it isn't accepted and they receive additional forms to complete.

SCDHHS Response: The State is unable to comment without additional information.

Rates/Billing/Cost Cap

- A commenter questioned why they do not receive full reimbursement as a service provider.

SCDHHS Response: Medicaid enrolled/contracted providers receive full Medicaid reimbursement if it is consistent with the amount submitted on the claim.

- Two commenters questioned why/if providers are able to direct bill with SCDHHS.

SCDHHS Response: A provider must be enrolled/contracted with SCDHHS in order to direct bill with Medicaid.

- A commenter indicated the rates were a bit of a concern since there was no administrative contract.

SCDHHS Response: When CMS approves the SCDDSN administrative contract, the State will evaluate rates for any needed adjustments.

- Two commenters asked about the new cost cap amounts.

SCDHHS Response: The proposed CS Waiver Cost Caps are reflected in the draft waiver document: Year 1: $14,760, Year 2: $15,203, Year 3: $15,659, Year 4: $16,128: and Year 5: $16,612.

Miscellaneous

- A commenter indicated the wording in CS Waiver is somewhat confusing.

SCDHHS Response: The State is unable to comment without additional information.

- A commenter questioned a personal appeal.

SCDHHS Response: The CS Waiver renewal process does not affect an individual's appeal status.

- A commenter asked if she could have a copy of the Powerpoint Presentation.

SCDHHS Response: The presentation will be available on www.scdhhs.gov until March 31, 2017.

- Two commenters asked how many slots would be added/allocated.

SCDHHS Response: The proposed additional slots are included in the draft waiver document: Year 1: 5800, Year 2: 6380, Year 3: 7020, Year 4: 7720, Year 5: 8500. The number of allocated slots depends on available funding as determined by the State Legislature.

- A commenter questioned the description of how DDSN communicates with providers in Appendix H.

SCDHHS Response: In response to this comment, the State has updated Appendix H in the waiver application.

Appendix A: Waiver Administration and Operation

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

○ **The waiver is operated by the state Medicaid agency.**

Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program *(select one)*:

○ **The Medical Assistance Unit.**

Specify the unit name:

(Do not complete item A-2)

○ **Another division/unit within the state Medicaid agency that is separate from the Medical Assistance Unit.**

Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

(Complete item A-2-a).

◉ **The waiver is operated by a separate agency of the state that is not a division/unit of the Medicaid agency.**

Specify the division/unit name:

The South Carolina Department of Disabilities and Special Needs (DDSN)

In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *(Complete item A-2-b).*

Appendix A: Waiver Administration and Operation

2. **Oversight of Performance.**

a. **Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:
As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.

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

DHHS and DDSN have a Memorandum of Agreement (MOA) to ensure an understanding between agencies regarding the operation and administration of the CS waiver. The MOA delineates the waiver will be operated by DDSN under the oversight of DHHS. The MOA specifies the following:

• Purpose
• Scope of Services
• Fiscal Administration
• Terms and Conditions
• Appendices

The MOA is renewed at least every five (5) years and amended as needed.

DHHS and DDSN are implementing an administrative contract regarding the operation and administration of the ID/RD, HASCI, PDD, and CS waivers to facilitate the delivery of Medicaid waiver services, and state plan services. It is the intent of both parties to enhance interagency communication and coordination.

DHHS and DDSN also have a waiver service contract to outline the requirements and responsibilities for the provision of waiver services by the operating agency. The waiver service contract is renewed at least every five (5) years and amended as needed.

The waiver service contract includes the following:
• Definition of Terms
• Scope of Services
• SCDDSN Responsibilities
• Conditions for Reimbursement by SCDHHS
• Records and Audits
• Termination of Contract
• Appeals Procedures
• Covenants and Conditions
• Appendices

DHHS utilizes various quality assurance methods to evaluate DDSN's compliance with the MOA, the administrative contract, and Medicaid waiver policy. DHHS uses a CMS approved Quality Improvement Organization (QIO), quality assurance staff, and other agency staff to continuously evaluate the DDSN's quality management processes to ensure compliance.

The following describes the roles of each entity:

-CMS Approved QIO: Conducts validation reviews of a representative sample of initial level of care determinations performed by DDSN. Reports are produced and shared with DDSN, who is responsible for remedial actions as necessary within 45 days.

-DHHS QA staff: Conducts periodic quality assurance reviews. 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, within 45 days.

-DHHS QA staff: Utilizes other systems such as Medicaid Management Information Systems (MMIS) and Truven Analytics Healthcare 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 DDSN 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.

To ensure compliance of quality and general operating effectiveness, the State will conduct a review of the Operating Agency(SCDDSN) at least annually. More frequent reviews may be warranted as a result of consumer

complaints or identification of non-compliance by other means.

Appendix A: Waiver Administration and Operation

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

◉ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

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/ID levels of care determined by DDSN.

DDSN contracts with the University of South Carolina Center for Disability Resources which will provide assistance with the self-directed service 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.

DHHS contracts periodically with an independent entity to perform validation reviews, focus reviews and trend analysis.

○ **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

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

○ **Not applicable**

◉ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions.
Check each that applies:

☒ **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

Specify the nature of these agencies and complete items A-5 and A-6:

DDSN contracts with the local Disabilities and Special Needs(DSN) Board providers. Case Managers at the DSN Boards prepare the Plans of Service and complete Level of Care re-evaluations for the ICF/IID Level of Care.

☒ **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 contracts with approved /qualified private providers for Case Management who prepare the Plans of Service and complete the Level of Care re-evaluations for ICF/IID Level of Care.

Appendix A: Waiver Administration and Operation

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

DDSN will assess the performance of its contracted local/regional non-state entities responsible for conducting waiver operational functions on a 12-18 month cycle.

DHHS QA staff will conduct quarterly reviews of 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.

DHHS Quality Assurance (QA) staff will conduct quarterly reviews of waiver administrative functions performed by the DHHS-contracted QIO.

Additionally, upon request, DHHS Medicaid Program Integrity (MPI) conducts reviews.

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

The DHHS/DDSN MOA sets 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 Quality Improvement Organization (QIO) to assess the local DSN Boards and other qualified providers on a twelve to eighteen month cycle depending on the provider's past performance. 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/other approved providers and to DDSN. DDSN will provide technical assistance to the local Boards/other approved providers. Copies of all reviews and the Report of Findings are shared with DHHS within 45 days of completion. 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 within 30 days of completion. 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 within 30 days of completion. 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 within 30 days of completion. DHHS will review DDSN Internal Audit Division annual reports, special request audits, and fraudulent case investigations and request remedial action(s) as determined necessary.

DHHS will utilize: 1) a Quality Improvement Organization (QIO) to conduct QA reviews of a representative sample of initial Level of Care Determinations performed by DDSN; 2) QA staff to conduct periodic quality assurance focus reviews on the CMS quality assurance indicators and performance measures; and 3) Other DHHS Staff to conduct utilization reviews of DDSN as warranted. DDSN is to take remedial actions as necessary in a timely manner upon receipt of a report of findings from DHHS.

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

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	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	☒	☒	☒	☒

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
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	☒	☒	☒	☒

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

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

i. Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. *As necessary and applicable, performance measures should focus on:*

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver
- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

Where possible, include numerator/denominator.

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

Performance Measure:
DHHS will conduct desk/focus reviews and/or utilization reviews as related to waiver functions as outlined in the MOA. N= Number of desk/focus reviews and/or utilization reviews with findings; D= total number of reviews conducted.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DHHS Desk/Focus and/or Utilization 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**	☐ **Weekly**	☐ **100% Review**

Agency		
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = +/- 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☒ **Other** Specify: Sampling determined by evidence warranting a special review.
	☒ **Other** Specify: as warranted	

Data Aggregation and Analysis:

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

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

Performance Measure:
Policy changes related to the CS waiver are approved by DHHS prior to implementation by DDSN. N= Number of waiver policy changes approved by DHHS prior to implementation; D= total number of changes implemented.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Policy/Memo/Change Logs/ Bulletins

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

Data Aggregation and Analysis:

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

Performance Measure:
Level of Care determinations are reviewed by the DHHS QIO Contractor as required. N= Number of initial level of care determinations that meet criteria; D= total number of initial level of care determinations reviewed.

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Adverse Level of Care determinations are reviewed by the DHHS QIO contractor as required. N= Number of adverse level of care determinations the contractor agreed with; D= total number of adverse level of care determinations.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DHHS 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: DHHS QIO	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
DHHS will conduct reviews of findings of the DDSN QIO Quality Contractor. N= Number of records consistent with findings; D= total number of records reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
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**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☒ **Other** Specify: As warranted
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States 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.

DHHS produces reports of findings based on reviews. These reports are shared with DDSN to address identified issues, as warranted, through a remediation plan, which may include training, policy corrections, or financial adjustments for Federal Financial Participation. The report of findings identifies issues such as untimely level of care re-evaluations, incomplete service plans, and/or incorrect billings to Medicaid. DDSN is responsible for developing and implementing remedial actions to prevent future occurrences of the same issues.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

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

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

c. Timelines

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

- (●) **No**
- ( ) **Yes**

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

Appendix B: Participant Access and Eligibility

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

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

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☐ **Aged or Disabled, or Both - General**					
	☐	**Aged**			☐
	☐	**Disabled (Physical)**			
	☐	**Disabled (Other)**			
☐ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	**Brain Injury**			☐
	☐	**HIV/AIDS**			☐
	☐	**Medically Fragile**			☐
	☐	**Technology Dependent**			☐
☒ **Intellectual Disability or Developmental Disability, or Both**					
	☐	**Autism**			☐
	☐	**Developmental Disability**			☐
	☒	**Intellectual Disability**	0		☒
☐ **Mental Illness**					
	☐	**Mental Illness**			☐
	☐	**Serious Emotional Disturbance**			

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

Related Disability as defined by Section 44-20-30 of the South Carolina Code of Laws and 42 CPR 435.1009 as amended by 42 CFR 435.1010

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: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

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

- ( ) **No Cost Limit.** The state does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*
- ( ) **Cost Limit in Excess of Institutional Costs.** The state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the state. *Complete Items B-2-b and B-2-c.*

  The limit specified by the state is *(select one)*

  - ( ) **A level higher than 100% of the institutional average.**

    Specify the percentage:

  - ( ) **Other**

    Specify:

- ( ) **Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*
- (●) **Cost Limit Lower Than Institutional Costs.** The state refuses entrance to the waiver to any otherwise qualified individual when the state reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the state that is less than the cost of a level of care specified for the waiver.

  Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.

Year 1 = $14,928
Year 2 = $15,852
Year 3 = $16,833
Year 4 = $17,338
Year 5 = $17,858

These amounts are based on historical analysis and service utilization. Amounts are expected to increase each year by 3% for a cost of living adjustment. In each year since the waiver was developed, the individual cost cap has been determined to be reasonable and sufficient to meet the waiver needs of the participants living in their homes in the community. If, however, the waiver participant or caregiver's circumstances change suddenly requiring a greater level of need which is expected to last indefinitely, there is the possibility of a transfer to the ID/RD waiver or another form of long term care, where appropriate.

Waiver Case Management costs are excluded from a participant's total waiver service costs for the purpose of comparing participant's total waiver service costs against the cost limit.

The cost limit specified by the state is *(select one)*:

○ **The following dollar amount:**

Specify dollar amount:

The dollar amount *(select one)*

○ **Is adjusted each year that the waiver is in effect by applying the following formula:**

Specify the formula:

○ **May be adjusted during the period the waiver is in effect. The state will submit a waiver amendment to CMS to adjust the dollar amount.**

○ **The following percentage that is less than 100% of the institutional average:**

Specify percent:

◉ **Other:**

Specify:

Year 1 = $14,928
Year 2 = $15,852
Year 3 = $16,833
Year 4 = $17,338
Year 5 = $17,858

Waiver Case Management costs are excluded from a participant's total waiver service costs for the purpose of comparing participant's total waiver service costs against the cost limit.

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

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 waiver case manager, 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 anticipated costs do not exceed the specified cost limit and health and welfare can be reasonably assured. Applicants denied waiver entry for these reasons will be notified of the opportunity to request a fair hearing.

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

☒ **The participant is referred to another waiver that can accommodate the individual's needs.**

☒ **Additional services in excess of the individual cost limit may be authorized.**

Specify the procedures for authorizing additional services, including the amount that may be authorized:

In the event of a short-term, unanticipated, urgent change in the waiver participant's needs, the individual cost limit may be exceeded by up to $1,000, funded by all state dollars. Requests for exceeding the cost limit must be submitted to DDSN for review and approval. Otherwise, participants who are assessed to have long-term/ongoing needs (e.g. 6 months) that will now likely exceed the individual cost cap due to unexpected or sudden changes in the: 1) participant's living arrangements; 2) caregiver status; or 3) participant's health, will be considered for the State's waiver transfer policy. In order to be approved for the transfer, the CS Waiver participant must have a need that is directly related to the unexpected or sudden change in circumstances. If the participant meets the criteria and he/she requires services in greater amount/frequency, and/or requires nursing and/or residential habilitation, the waiver transfer policy allows participants of the Community Supports (CS) waiver to transfer to the Intellectually Disabled/Related Disabilities (ID/RD) waiver in order to avoid an adverse impact on the participant. CS waiver participants approved to transfer can by-pass the ID/RD waiver waiting list. The waiver transfer policy is not intended to allow individuals to transfer due to inattention to the individual cost limit per year. The waiver transfer policy is not intended to cover scenarios whereby participants transfer to the ID/RD waiver for the purpose of seeking a different waiver service package.

☐ **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	5800
Year 2	6380
Year 3	

Waiver Year	Unduplicated Number of Participants
	7020
Year 4	7720
Year 5	8500

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	5750
Year 2	6330
Year 3	6970
Year 4	7670
Year 5	8450

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

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

○ **Not applicable. The state does not reserve capacity.**

◉ **The state reserves capacity for the following purpose(s).**

Purpose(s) the state reserves capacity for:

Purposes
Family members of a member of the Armed Services who maintains South Carolina residency.
Individuals receiving State-Funded Day services.
Participants enrolled in the ID/RD Waiver who choose to enroll in the CS waiver.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup):*

Family members of a member of the Armed Services who maintains South Carolina residency.

Purpose *(describe):*

Eligible family members of a member of the armed services who maintains a South Carolina residence, regardless of where the service member is stationed, will maintain waiver status. A family member on the waiting list would return to the same place on the processing list when the family returns to South Carolina. An eligible family member previously enrolled in the waiver program would be reinstated into the waiver program once South Carolina Medicaid eligibility is established upon their return to South Carolina. No services will be provided outside the South Carolina Medicaid Service Area.

Describe how the amount of reserved capacity was determined:

The amount reserved is based on estimates for these purposes.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	10
Year 2	10
Year 3	10
Year 4	10
Year 5	10

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup):*

Individuals receiving State-Funded Day services.

Purpose *(describe):*

Those individuals already receiving State-funded Day services.

Describe how the amount of reserved capacity was determined:

The reserved capacity amount was determined based on the number of individuals currently receiving State-funded Day services.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	50
Year 2	50
Year 3	50
Year 4	50
Year 5	50

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup):*

Participants enrolled in the ID/RD Waiver who choose to enroll in the CS waiver.

Purpose *(describe):*

Furnish waiver services to those participants currently enrolled in the ID/RD Waiver who choose to enroll in the CS waiver.

Describe how the amount of reserved capacity was determined:

This number was based on the estimated number of ID/RD Waiver participants who may choose to enter the CS waiver.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	25
Year 2	25
Year 3	25
Year 4	25
Year 5	25

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (3 of 4)

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

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

e. Allocation of Waiver Capacity.

Select one:

- (●) **Waiver capacity is allocated/managed on a statewide basis.**
- ( ) **Waiver capacity is allocated to local/regional non-state entities.**

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

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

The Community Supports Waiver includes reserved capacity for three (3) groups of people: 1) those individuals with Intellectual Disabilities/Related Disabilities who are participants in the States ID/RD Waiver; 2) those individuals with ID/RD who currently receive DDSN funded day services; and 3) Family members of a member of the Armed Services who maintain SC residency.

Upon disenrollment from the ID/RD Waiver, or as appropriate, for those currently receiving DDSN-funded Day Services, 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, applicant 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.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

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

- (●) **§1634 State**
- ( ) **SSI Criteria State**
- ( ) **209(b) State**

2. Miller Trust State.
Indicate whether the state is a Miller Trust State *(select one)*:

- ( ) **No**
- (●) **Yes**

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

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)

- [ ] **Low income families with children as provided in §1931 of the Act**
- [x] **SSI recipients**
- [ ] **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- [x] **Optional state supplement recipients**
- [x] **Optional categorically needy aged and/or disabled individuals who have income at:**

Select one:

- (●) **100% of the Federal poverty level (FPL)**
- ( ) **% of FPL, which is lower than 100% of FPL.**

Specify percentage:

☐ **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**

☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**

☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**

☒ **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**

☐ **Medically needy in 209(b) States (42 CFR §435.330)**

☐ **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**

☐ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)**

Specify:

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

○ **No. The state does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.** *Appendix B-5 is not submitted.*

◉ **Yes. The state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.**

Select one and complete Appendix B-5.

◉ **All individuals in the special home and community-based waiver group under 42 CFR §435.217**

○ **Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217**

Check each that applies:

☐ **A special income level equal to:**

Select one:

○ **300% of the SSI Federal Benefit Rate (FBR)**

○ **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage:

○ **A dollar amount which is lower than 300%.**

Specify dollar amount:

☐ **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**

☐ **Medically needy without spend down in states which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**

☐ **Medically needy without spend down in 209(b) States (42 CFR §435.330)**

☐ **Aged and disabled individuals who have income at:**

Select one:

○ **100% of FPL**

○ **% of FPL, which is lower than 100%.**

Specify percentage amount:

☐ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 7)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group.

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

Note: For the period beginning January 1, 2014 and extending through September 30, 2019 (or other date as required by law), the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

☒ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses *spousal* post-eligibility rules under §1924 of the Act.**
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law).

Note: The following selections apply for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law) (select one).

◉ **Spousal impoverishment rules under §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 Item B-5-b (SSI State) and Item B-5-d)

○ **Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

○ **Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The state uses regular post-eligibility rules for individuals with a community spouse.**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

b. Regular Post-Eligibility Treatment of Income: SSI State.

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

i. Allowance for the needs of the waiver participant (*select one*):

- (●) **The following standard included under the state plan**

  Select one:

  - ( ) **SSI standard**
  - ( ) **Optional state supplement standard**
  - ( ) **Medically needy income standard**
  - (●) **The special income level for institutionalized persons**

    (*select one*):

    - (●) **300% of the SSI Federal Benefit Rate (FBR)**
    - ( ) **A percentage of the FBR, which is less than 300%**

      Specify the percentage:
    - ( ) **A dollar amount which is less than 300%.**

      Specify dollar amount:
  - ( ) **A percentage of the Federal poverty level**

    Specify percentage:
  - ( ) **Other standard included under the state Plan**

    Specify:

- ( ) **The following dollar amount**

  Specify dollar amount: If this amount changes, this item will be revised.
- ( ) **The following formula is used to determine the needs allowance:**

  Specify:

- ( ) **Other**

  Specify:

ii. Allowance for the spouse only (*select one*):

- (●) **Not Applicable**
- ( ) **The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:**

Specify:

Specify the amount of the allowance (*select one*):

- ( ) **SSI standard**
- ( ) **Optional state supplement standard**
- ( ) **Medically needy income standard**
- ( ) **The following dollar amount:**

Specify dollar amount: [ ] If this amount changes, this item will be revised.

- ( ) **The amount is determined using the following formula:**

Specify:

iii. Allowance for the family (*select one*):

- ( ) **Not Applicable (see instructions)**
- (●) **AFDC need standard**
- ( ) **Medically needy income standard**
- ( ) **The following dollar amount:**

Specify dollar amount: [ ] The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the state's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

- ( ) **The amount is determined using the following formula:**

Specify:

- ( ) **Other**

Specify:

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

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

- ○ **Not Applicable (see instructions)***Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*
- ○ **The state does not establish reasonable limits.**
- ◉ **The state establishes the following reasonable limits**

Specify:

State Plan: Supplement 3 to attachment 2.6-A

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

c. Regular Post-Eligibility Treatment of Income: 209(B) State.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

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

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

i. Allowance for the personal needs of the waiver participant

(*select one*):

- ○ **SSI standard**
- ○ **Optional state supplement standard**
- ○ **Medically needy income standard**
- ◉ **The special income level for institutionalized persons**
- ○ **A percentage of the Federal poverty level**

  Specify percentage:
- ○ **The following dollar amount:**

  Specify dollar amount: If this amount changes, this item will be revised
- ○ **The following formula is used to determine the needs allowance:**

Specify formula:

○ **Other**

Specify:

ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.

Select one:

◉ **Allowance is the same**
○ **Allowance is different.**

Explanation of difference:

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

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

○ **Not Applicable (see instructions)***Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*
○ **The state does not establish reasonable limits.**
◉ **The state uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (5 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

e. Regular Post-Eligibility Treatment of Income: §1634 State - 2014 through 2018.

Answers provided in Appendix B-5-a indicate the selections in B-5-b also apply to B-5-e.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (6 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

f. Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (7 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018.

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

Answers provided in Appendix B-5-a indicate the selections in B-5-d also apply to B-5-g.

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 2

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:

The State requires the provision of waiver services at least monthly with one exception. The State allows up to 60 days for a new enrollee to receive his/her first service (other than waiver case management). Thereafter, the State requires the provision of waiver services at least monthly.

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 a government agency under contract with the Medicaid agency.**

Specify the entity:

◉ **Other**
Specify:

This waiver uses the ICF/IID level of care when assessing potential waiver eligibility. The initial level of care evaluation is performed by the DDSN Consumer Assessment Team (CAT). LOC reevaluations are completed by waiver case managers and early intervention (WCM/EI) providers. In some instances reevaluations are conducted by the CAT. Internal policy dictates when this is required. This generally becomes necessary when the case manager has overlooked the LOC due date or the LOC has expired for other reasons.

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 Team: 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 Masters degree in Applied Psych and 5 years experience in practice subsequent to Masters degree; or possession of current licensure to practice psychology in South Carolina.

Psychologist: Minimum qualifications are a Masters degree in psychology and 4 years of clinical experience subsequent to Masters 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 Facility/Individuals with Intellectual Disability issued by DHHS states:

Eligibility for Medicaid sponsored Intermediate Care Facility-Individuals with Intellectual Disability (ICF/IID) in South Carolina consists of meeting the following criteria:

1. The person has a confirmed diagnosis of intellectual disability, 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.

"Intellectual Disability" 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 22 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 persons 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/IID.

Because no set of criteria can adequately describe all the possible circumstances, knowledge of an individuals particular situation is essential in applying these criteria. Professional judgment is used in rating the individuals 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 waiver case manager collects documents/information regarding the applicants condition, need for supervision, and need for services. The gathered information is reviewed by DDSN's Consumer Assessment Team who determines if level of care criteria is met.

Reevaluation: information regarding the participants current condition, need for supervision, and need for services is reviewed by the participants waiver case manager (or the CAT as needed), and a determination is made.

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

- ○ **Every three months**
- ○ **Every six months**
- ○ **Every twelve months**
- ◉ **Other schedule**

Specify the other schedule:

Conducted at least annually (within every 365 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.**

Specify the qualifications:

Waiver Case Managers must possess a bachelor’s degree from an accredited college or university, or licensure from the South Carolina Department of Labor, Licensing and Regulation Board as a Registered Nurse,

And

Documentation of at least one year of experience working with people with intellectual disabilities and related disabilities, autism, traumatic brain injury and/or spinal cord injury and/or one year of case management experience. The degree must be from an institution accredited by a nationally recognized educational accrediting body.

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 system produced by DDSN tracks due dates and timing of reevaluations and alerts the waiver case manager/early interventionist and/or his/her supervisor to its impending due date. Additionally, if any level of care determination is found out of date, FFP is recouped from DDSN for all services that were billed when the level of care determination 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:

Written and electronically retrievable documents are housed with the contracted providers of DDSN.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States

methods for discovery and remediation.

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

The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.

i. Sub-Assurances:

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

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
Community Supports waiver enrollees have a Level of Care determination completed within 30 days prior to waiver enrollment. N= Number of new CS waiver enrollees whose LOC determination was completed within 30 days prior to waiver enrollment; D= total number of new enrollees in the CS waiver.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DDSN Waiver Enrollment 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**	☐ **Stratified** Describe Group:

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
DHHS Waiver Enrollment 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**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

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

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
Level of Care determinations are conducted using the appropriate criteria and instrument. N= Number of CS waiver level of care determinations that were conducted using the appropriate criteria and instrument; D= total number of CS waiver level of care determinations reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DHHS 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: DHHS QIO Contractor	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☒ **Other** Specify: Sampling is determined by evidence warranting a special review.
	☐ **Other**	

	Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: DHHS QIO Contractor	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States 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's QIO identifies problems thru the review process, the provider is required to submit a plan of correction to address each specific finding. The QIO conducts a follow-up review to confirm the corrections have been made. Additionally, QIO reports are reviewed by DDSN Operations staff. As needed, technical assistance is provided to providers by the Operations staff. Documentation of all technical assistance is available. DDSN QIO reviews, provider plans of correction and QIO follow-up review results are available to DHHS. On a monthly basis, the DHHS QIO randomly pulls a sample of all new LOC determinations and re-determinations for CS participants to verify accuracy. In addition, 100% of all adverse LOC determinations are reviewed.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: DHHS QIO Contractor	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

Long-term care options are discussed with potentially eligible individuals, families, legal guardians and/or representatives during the assessment and subsequent visits.

Prior to waiver enrollment, the Case Manager explains the options of choosing institutional vs. at home care. A Freedom of Choice Form is then 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 18th birthday, the current form or a new form is signed within 90 days following the participant's 18th birthday.

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: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency Persons

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

The operating agency's (DDSN) policy entitled "Compliance with Title VI of the Civil Rights Act of 1964, American Disabilities Act of 1990, Age Discrimination Act of 1975 and Section 504 of the Rehabilitation Act of 1973 and Establishment of the Complaint Process" (700-02-DD) describes the methods DDSN utilizes to provide meaningful access to the waiver services by persons with limited English proficiency. As specified in DDSN policy, when required, WCM providers can access funds to pay for an interpreter to provide meaningful access to the waiver. Additionally, the State utilizes telephone interpreter services and written materials translation services.

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

a. Waiver Services Summary. *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

Service Type	Service		
Statutory Service	**Adult Day Health Care Services**		
Statutory Service	**Personal Care Services**		
Statutory Service	**Respite Care Services**		
Statutory Service	**Waiver Case Management (WCM)**		
Extended State Plan Service	**Incontinence Supplies**		
Other Service	**Adult Day Health Care Nursing**		
Other Service	**Adult Day Health Care Transportation**		
Other Service	**Assistive Technology and Appliances Assessment/Consultation**		
Other Service	**Assistive Technology and Appliances**		
Other Service	**BEHAVIOR SUPPORT SERVICES**		
Other Service	**CAREER PREPARATION SERVICES**		
Other Service	**COMMUNITY SERVICES**		
Other Service	**DAY ACTIVITY**		
Other Service	**EMPLOYMENT SERVICES**		
Other Service	**Environmental Modifications**		

Service Type	Service		
Other Service	**In-Home Support services**		
Other Service	**Personal Emergency Response Systems (PERS)**		
Other Service	**Private Vehicle Assessment/Consultation**		
Other Service	**PRIVATE VEHICLE MODIFICATIONS**		
Other Service	**SUPPORT CENTER SERVICES**		

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Adult Day Health

Alternate Service Title (if any):

Adult Day Health Care Services

HCBS Taxonomy:

Category 1: 04 Day Services

Sub-Category 1: 04020 day habilitation

Category 2: 04 Day Services

Sub-Category 2: 04050 adult day health

Category 3:

Sub-Category 3:

Service Definition *(Scope):*

Category 4:

Sub-Category 4:

Services furnished 5 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 recipients need for the service as identified and documented in the individuals 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 individuals 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:

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☒ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Adult Day Health Care Provider

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Adult Day Health Care Services

Provider Category:

Agency

Provider Type:

Adult Day Health Care Provider

Provider Qualifications

License *(specify):*

SC Code Annotated §44-7; 25 SC Code Annual Regulations 61-75 (1976)

Certificate *(specify):*

Other Standard *(specify):*

Contracted with DHHS for Adult Day Health Care; Contract scope of service

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Health and Environmental Control; DHHS

Frequency of Verification:

Upon contract; at least every 18 months

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Personal Care

Alternate Service Title (if any):

Personal Care Services

HCBS Taxonomy:

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

Service Definition *(Scope):*

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:

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☒ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Personal Care Providers

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal Care Services

Provider Category:

Agency

Provider Type:

Personal Care Providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Personal Care I Providers that the provider must meet the following qualifications:
1. A supervisor who meets the following requirements:
a. High school diploma or equivalent
b. Capable of evaluating aides in terms of their ability to carry out assigned duties and their ability to relate to the participant
c. Able to assume responsibility for in-service training for aides by individual instruction, group meetings, or workshops
2. Aides who meet the following minimum qualifications:
a. Able to read, write and communicate effectively with participant or supervisor b. Able to use the Care Call IVR system
c. Capable of following a care plan with minimal supervision
d. Be at least 18 years of age
e. Have documented record of having completed six (6) hours of training in the areas indicated in Section D.2.f, prior to providing services or documentation of personal, volunteer or paid experience in the care of adults, families and/or the disabled, home management, household duties, preparation of food, and be able to communicate observations verbally and in writing
f. Complete at least six (6) hours in-service training per calendar year in the following areas:
i. Maintaining a safe, clean environment and utilizing proper infection control techniques;
ii. Following written instructions;
iii. Providing care including individual safety, laundry, meal planning, preparation and serving, and household management;
iv. First aid;
v. Ethics and interpersonal relationships;
vi. Documenting services provided;
vii. Home support: - Cleaning - Laundry - Shopping - Home safety - Errands - Observing and reporting the participant's condition

Personal Care II providers must meet the following qualifications:
1. The provider must provide for all of the following staff members; but supervisory nurses may be provided through subcontracting arrangements:
a. A registered nurse(s) (RN) or licensed practical nurse(s) (LPN) who meets the following requirements: Currently licensed by the S.C. State Board of Nursing
ii. Capable of evaluating the aide’s competency in terms of his or her ability to carry out assigned duties and his/her ability to relate to the participant
iii. Able to assume responsibility for in-service training for aides by individual instruction, group meetings or workshops
iv. Must have had background and/or training on the complex treatment issues regarding the care of the head and spinal cord injured
v. Provider will verify nurse licensure at time of employment and will ensure that the license remains active and in good standing at all times during employment. Provider must maintain a copy of the current license in the employee’s personnel file. Nurse licensure can be verified at the State Board of nursing website http://www.llr.state.sc.us/pol.asp
b. Aides who meet the following minimum qualifications:
i. Able to read, write, and communicate effectively with participant and supervisor
ii. Able to use the Care Call IVR system
iii. Capable of assisting with the activities of daily living
iv. Capable of following a care plan with minimal supervision. v. Have a valid driver’s license if transporting participants. The provider must ensure the employee’s license is valid while transporting any participants by verifying the official highway department driving record of the employed individual initially and every two (2) years during employment. Copies of the initial and subsequent driving records must be maintained in the employee’s personnel file.
vi. Are at least 18 years of age
vii. Have passed competency testing or successfully completed a competency training and evaluation program performed by an RN or LPN prior to providing services to Home and Community Based waiver participants. The competency evaluation must contain all elements of the PC II services in the Description of Services listed above. The competency training should also include training on appropriate record keeping and ethics and interpersonal relationships.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHHS

Frequency of Verification:

Upon contract; at least every 18 months.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

Respite Care Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
09 Caregiver Support	09011 respite, out-of-home
Category 2:	**Sub-Category 2:**
09 Caregiver Support	09012 respite, in-home
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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. 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:
Individuals home or other private residence selected by the participant/representative;
Group home;
Foster home;
Medicaid certified nursing facility;
Medicaid certified ICF/IID; and/or,
Licensed Community Residential Care facility.

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

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**
☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**
☒ **Relative**
☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Personal Care Provider
Agency	DSS Licensed Foster Home
Agency	Medicaid certified nursing facility
Agency	Licensed Community Residential Care Facility
Agency	Medicaid Certified ICF/IID
Agency	DDSN

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite Care Services

Provider Category:
Agency
Provider Type:

Personal Care Provider

Provider Qualifications
License *(specify):*

Contract and enroll with DHHS for respite services/personal care II services.

Certificate *(specify):*

Other Standard *(specify):*

Contract and enroll with DHHS for respite services and must meet the following qualifications:
o Be at least 18 years of age.
o Have the ability to speak, read, and write English.
o Be capable of aiding in the activities of daily living.
o Be capable of following the Plan of Care with minimal supervision.
o Have no record of abuse, neglect, crimes committed against another or felonious conviction of any kind.
o Be free of communicable diseases.
o Possess a valid driver's license if required as part of the job.
o Other provider requirements include:
Settings must provide for the individual or his/her representative acknowledgment that the setting in which the service will be provided was chosen by them and has not been licensed, inspected or approved by DDSN or the contracted service provider.
a. The caregiver/respite provider must demonstrate competency by successful completion of exams designed to measure knowledge in the areas of: Confidentiality
b. Supervision
c. Prevention of abuse & neglect
d. First aid

Verification of Provider Qualifications

Entity Responsible for Verification:

DHHS

Frequency of Verification:

Upon enrollment, and at least every 18 months

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite Care Services

Provider Category:

Agency

Provider Type:

DSS Licensed Foster Home

Provider Qualifications

License *(specify):*

SC Code Ann.§44-20

Certificate *(specify):*

Other Standard *(specify):*

DDSN Respite Standards/DDSN Residential Habilitation Standards

Verification of Provider Qualifications

Entity Responsible for Verification:

DDSN

Frequency of Verification:

Upon enrollment and annually.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite Care Services

Provider Category:

Agency

Provider Type:

Medicaid certified nursing facility

Provider Qualifications

License *(specify):*

SC Code, Sec. 44-7

Certificate *(specify):*

Other Standard *(specify):*

Contracted with DHHS for Institutional Respite; contract contains the scope of service.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHEC; DHHS

Frequency of Verification:

Upon contract; Annually

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite Care Services

Provider Category:

Agency

Provider Type:

Licensed Community Residential Care Facility

Provider Qualifications

License *(specify):*

SC Code, Sec. 44-7

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

DHEC; DHHS

Frequency of Verification:

Upon Contract; Annually

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite Care Services

Provider Category:

Agency

Provider Type:

Medicaid Certified ICF/IID

Provider Qualifications

License *(specify):*

SC Code Ann 44-7

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

DHEC

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite Care Services

Provider Category:

Agency

Provider Type:

DDSN

Provider Qualifications

License *(specify):*

SC Code Ann. §44-20

Certificate *(specify):*

Other Standard *(specify):*

DDSN Respite Standards

Verification of Provider Qualifications

Entity Responsible for Verification:

DDSN; DHEC

Frequency of Verification:

Upon enrollment; Annually; QIO Reviews are conducted on a 12-18 month cycle depending on past provider performance.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Case Management

Alternate Service Title (if any):

Waiver Case Management (WCM)

HCBS Taxonomy:

Category 1:	Sub-Category 1:
01 Case Management	01010 case management
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Services that assist participants in gaining access to needed waiver and other State plan, regardless of the funding sources for the services to which access is gained. Waiver case managers are responsible for initiating and/or conducting the process to evaluate and/or re-evaluate the individual's level of care as specified in waiver policy. Waiver case managers are responsible for conducting assessments and developing service plans as specified in waiver policy. This includes the ongoing monitoring of the provision of services included in the participant's service plan. Waiver case managers are responsible for the ongoing monitoring of the participant's health and welfare, which may include crisis intervention, and referral to non-waiver services.

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

Participants may receive no more than 10 hours per calendar quarter. In exceptional cases, where medical necessity has been demonstrated, additional hours can be approved through a prior authorization process.

Participants may not receive Medicaid Targeted Case Management in place of Waiver Case Management.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Waiver Case Management Provider

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Waiver Case Management (WCM)

Provider Category:

Agency

Provider Type:

Waiver Case Management Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Possess a bachelor's degree from an accredited college or university, or licensure from the South Carolina Department of Labor, Licensing and Regulation Board as a Registered Nurse,

And

Documentation of at least one year of experience working with people with intellectual disabilities and related disabilities, autism, traumatic brain injury and/or spinal cord injury and/or one year of case management experience. The degree must be from an institution accredited by a nationally recognized educational accrediting body.

WCM may not be provided by a family member. A family member is defined as a relative, legal guardian, spouse, foster parent, or anyone with an in-law or step relationship.

The DSN Board or qualified provider must comply with SCDDSN or SCDHHS Waiver Case Management Standards as applicable.

Verification of Provider Qualifications

Entity Responsible for Verification:

Qualified waiver case managers must meet these standards prior to employment. The provider agency who employs the case manager is responsible for ensuring case manager qualifications.

Frequency of Verification:

Upon employment and annually per standards.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Extended State Plan Service

Service Title:

Incontinence Supplies

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14032 supplies
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Diapers, under-pads, wipes, liners and disposable gloves provided to participants who are at least twenty-one (21) years old and who are incontinent of bowel and/or bladder according to established medical criteria.

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

The extended state plan waiver service may offer the following based on documented need in the participant record for adults age 21 and older, in addition to State Plan services:

*one (1) box of disposable gloves monthly;
*up to two (2) cases of diapers monthly;
*up to two (2) cases of under-pads monthly;
*up to eight (8) boxes of wipes monthly;
*up to two (2) boxes of liners monthly.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☒ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Incontinence Supply Provider

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Incontinence Supplies

Provider Category:

Agency

Provider Type:

Incontinence Supply Provider

Provider Qualifications

License *(specify):*

South Carolina business license

Certificate *(specify):*

Other Standard *(specify):*

Enrolled with DHHS to provide Incontinence Supplies

Verification of Provider Qualifications

Entity Responsible for Verification:

DHHS

Frequency of Verification:

Upon enrollment

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Adult Day Health Care Nursing

HCBS Taxonomy:

Category 1:	Sub-Category 1:
05 Nursing	05020 skilled nursing

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Service Definition *(Scope):*

Category 4: **Sub-Category 4:**

ADHC Nursing services are provided 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:

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☒ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Adult Day Health Care Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Adult Day Health Care Nursing

Provider Category:

Agency

Provider Type:

Adult Day Health Care Agency

Provider Qualifications

License *(specify):*

SC Code Ann. §44-77; 25 SC Code Ann. Regs. 61-75 (1976)

Certificate *(specify):*

Other Standard *(specify):*

Contracted with DHHS for Adult Day Health Care Services; ADHC-Nursing is an optional component of the contract.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHEC; DHHS

Frequency of Verification:

Upon contract; at least every 18 months.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Adult Day Health Care Transportation

HCBS Taxonomy:

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

Service Definition *(Scope):*

ADHC Transportation is prior-authorized for participants receiving the 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 participants 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:

ADHC Transportation services are limited to participants who reside within 15 miles of the ADHC Center. Participants receiving Residential Habilitation services paid at a daily rate cannot receive this service.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☒ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Adult Day Health Care Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Adult Day Health Care Transportation

Provider Category:

Agency

Provider Type:

Adult Day Health Care Agency

Provider Qualifications

License *(specify):*

SC Code Ann. §44-7; 25 SC Code Ann. Regs. 61-75 (1976)

Certificate *(specify):*

Other Standard *(specify):*

Contracted with DHHS to provide Adult Day Health Care Transportation using contract scope of service.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Health and Environmental Control; DHHS

Frequency of Verification:

Upon Enrollment;
At least every 18 months

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Assistive Technology and Appliances Assessment/Consultation

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14031 equipment and technology
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Assistive Technology and Appliances Assessment/Consultation may be provided (if not covered under the State Plan Medicaid)once a participant's specific need has been identified and documented in the Support Plan. The scope of the work and specifications must be determined. Consultation and assessment may include specific needs related to the participant's disability for which assistive technology and/or appliances will assist the participant to function more independently. Appliances intended for general household utility that do not result in a decrease in need for other waiver services are not covered. This service is not intended to replace traditional household appliances for the convenience of family/household members or caregivers. Additionally, devices, items, equipment and/or product systems not proven effective, or deemed trial or experimental are not covered.

Assistive technology and assessments/consultations must be provided by Medicaid enrolled Occupational or Physical Therapists, Medicaid enrolled Rehabilitation Engineering Technologists, Assistive Technology Practitioners and Assistive Technology Suppliers certified by the Rehabilitation Engineering Society of North American (RESNA), Medicaid enrolled Environmental Access/Consultants/contractors certified by Professional Resource in Management (PRIME).

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

The reimbursement for the consultation/assessment will not exceed $300

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	DHHS Enrolled Providers
Agency	DDSN/DSN Boards/Contracted Providers

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology and Appliances Assessment/Consultation

Provider Category:

Agency

Provider Type:

DHHS Enrolled Providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Enrolled with DHHS

Verification of Provider Qualifications

Entity Responsible for Verification:

DHHS

Frequency of Verification:

Upon enrollment

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology and Appliances Assessment/Consultation

Provider Category:

Agency

Provider Type:

DDSN/DSN Boards/Contracted Providers

Provider Qualifications

License *(specify):*

The DSN Board or qualified provider may employ or contract with the following for consultation, assessment, and/or follow-up inspection; the provider is responsible for verifying and documenting licensure or certification:
- Licensed Occupational Therapist
- Licensed Physical Therapist

Certificate *(specify):*

The DSN Board or qualified provider may employ or contract with the following for consultation, assessment, and/or follow-up inspection; the provider is responsible for verifying and documenting licensure or certification:
- Contractor licensed by the South Carolina Department of Labor, Licensing and Regulation (LLR) not enrolled with SCDHHS as a DME provider
- Vendor with a retail or wholesale business license that is not enrolled with SCDHHS as a DME provider
- Licensed Occupational Therapist
- Licensed Physical Therapist
- Rehabilitation Engineering Technologist (RET) certified by Rehabilitation Engineering Society of North American (RESNA)
- Assistive Technology Practitioner (ATP) certified by Rehabilitation Engineering Society of North American (RESNA)
- ATP Supplier certified by Rehabilitation Engineering Society of North American (RESNA)
- Environmental Access Consultant/contractor certified by Professional Resources in Management (PRIME)

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

DDSN

Frequency of Verification:

Prior to each assessment/consultation

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Assistive Technology and Appliances

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14031 equipment and technology
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Assistive Technology and/or Appliances means a device, an item, piece of equipment, or product system, that is used to increase or improve functional capabilities of participants thereby resulting in a decrease or avoidance of need for other waiver services (e.g., personal care, respite, etc.). This service may include training or technical assistance for the participant, or, where appropriate, the family members, guardians, advocates, or authorized representatives of the participant. Appliances intended for general household utility that do not result in a decrease in need for other waiver services are not covered. This service is not intended to replace traditional household appliances for the convenience of family/household members or caregivers. Additionally, devices, items, equipment and/or product systems not proven effective, or deemed trial or experimental are not covered. Repairs not covered by warranty are covered, and replacement of parts/equipment are covered, if these repairs or parts/equipment are not related to abuse, mistreatment or carelessness. The lifetime limit on repairs (not covered under warranty) and/or replacement of parts/equipment is $1,000. To the extent that any listed services are covered under the state plan, the services under the waiver would be limited to additional services not otherwise covered under the state plan, but consistent with waiver objectives of avoiding institutionalization.

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

The lifetime limit on repairs (not covered under warranty) and/or replacement of parts/equipment is $1,000.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☒ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	DHHS Enrolled Providers
Agency	DDSN/DSN Board/Contracted Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology and Appliances

Provider Category:

Agency

Provider Type:

DHHS Enrolled Providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Enrolled with DHHS

Verification of Provider Qualifications

Entity Responsible for Verification:

DHHS

Frequency of Verification:

Upon enrollment

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology and Appliances

Provider Category:

Agency

Provider Type:

DDSN/DSN Board/Contracted Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

DDSN Contract

Verification of Provider Qualifications

Entity Responsible for Verification:

DDSN

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

BEHAVIOR SUPPORT SERVICES

HCBS Taxonomy:

Category 1:	Sub-Category 1:
10 Other Mental Health and Behavioral Services	10040 behavior support
Category 2:	**Sub-Category 2:**

Category 3: **Sub-Category 3:**

Service Definition *(Scope):*

Category 4: **Sub-Category 4:**

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:

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☒ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Behavior Support Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: BEHAVIOR SUPPORT SERVICES

Provider Category:
Individual
Provider Type:

Behavior Support Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certification by the Behavior Analyst Certification Board as a Board Certified Behavior Analyst (BCBA or as a Board Certified Assistant Behavior Analyst(BCaBA)

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Verified/approved by DDSN and enrolled by DHHS.

Frequency of Verification:

Upon enrollment; verification of continuing education every two years.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

CAREER PREPARATION SERVICES

HCBS Taxonomy:

Category 1:	Sub-Category 1:
04 Day Services	04010 prevocational services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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 participants 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 participants residence to the habilitation site when the service start time is before 12:00 Noon. Transportation will be available from the participants 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:

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☒ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	DDSN (Day Services Provider)

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: CAREER PREPARATION SERVICES

Provider Category:

Agency

Provider Type:

DDSN (Day Services Provider)

Provider Qualifications

License *(specify):*

SC Code Annotated § 44-20; 26 SC Code Ann. Regs 88-105 thru 88-020 (1976)

Certificate *(specify):*

Other Standard *(specify):*

DDSN Career Preparation standards

Verification of Provider Qualifications

Entity Responsible for Verification:

DDSN

Frequency of Verification:

Initially; Annually; QIO Reviews are conducted on a 12-18 month cycle depending on past provider performance.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

COMMUNITY SERVICES

HCBS Taxonomy:

Category 1:	Sub-Category 1:
04 Day Services	04070 community integration
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Services aimed at developing ones 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 participants residence to the habilitation site when the service start time is before 12:00 Noon. Transportation will be available from the participants 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:

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☒ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	DDSN (Day Services Provider)

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: COMMUNITY SERVICES

Provider Category:

Agency

Provider Type:

DDSN (Day Services Provider)

Provider Qualifications

License *(specify):*

SC Code Annotated § 44-20; 26 SC Code Ann. Regs. 88-105 thru 88-920 (1976)

Certificate *(specify):*

Other Standard *(specify):*

DDSN Community Services Standards

Verification of Provider Qualifications

Entity Responsible for Verification:

DDSN

Frequency of Verification:

Initially; Annually; QIO Reviews are conducted on a 12-18 month cycle depending on past provider performance.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

DAY ACTIVITY

HCBS Taxonomy:

Category 1:	Sub-Category 1:
04 Day Services	04030 education services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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 participants residence to the habilitation site when the service start time is before 12:00 Noon. Transportation will be available from the participants 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:

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☒ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	DDSN (Day Services Provider)

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: DAY ACTIVITY

Provider Category:

Agency

Provider Type:

DDSN (Day Services Provider)

Provider Qualifications

License *(specify):*

SC Code Annotated § 44-20; 26 SC Code Ann. Regs. 88-105 thru 88-920 (1976)

Certificate *(specify):*

Other Standard *(specify):*

DDSN Standards for Day Activity Services

Verification of Provider Qualifications

Entity Responsible for Verification:

DDSN

Frequency of Verification:

Initially; Annually; QIO Reviews are conducted on a 12-18 month cycle depending on past provider performance.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

EMPLOYMENT SERVICES

HCBS Taxonomy:

Category 1:	Sub-Category 1:
03 Supported Employment	03021 ongoing supported employment, individual
Category 2:	**Sub-Category 2:**
03 Supported Employment	03022 ongoing supported employment, group
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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:

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☒ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Employment Services Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: EMPLOYMENT SERVICES

Provider Category:

Agency

Provider Type:

Employment Services Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Employment Services will be provided by staff who:
- Are at least 18 years of age.
- Have a valid high school diploma or its certified equivalent.
- Have references from past employment if the person has a 5 Standard Guidance work history.
- Are capable of aiding in the activities of daily living and implementing the Employment Services Plan of each person for whom they are responsible.
- Have a valid driver's license if duties require transportation of individuals.
- Have a background check
- Pass an initial physical exam prior to working in the program.
- Pass initial tuberculosis screening prior to working in the program and annually thereafter.
- Must be trained and be deemed competent in accordance with DDSN Directives.
- Will be a staff development/in-service education program operable in each provider agency which requires all staff to participate in in-service education programs and staff development opportunities in accordance with DDSN Directives
- DDSN EMPLOYMENT STANDARDS: http://ddsn.sc.gov/about/directives-standards/Documents/currentstandards/Employment%20Services%20Standards%20-%20Revised%20(070111).pdf

Verification of Provider Qualifications

Entity Responsible for Verification:

DDSN

Frequency of Verification:

Initially; QIO Reviews are conducted on a 12-18 month cycle depending on past provider performance.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Environmental Modifications

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Those physical adaptations to the home, required by the individuals 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 case manager based on the participant's need as documented in the plan of care. Three bids for the modification are obtained by the case manager and submitted with documentation of the need. The consultation/assessment does not require the submission of bids. This information is reviewed by SCDDSN staff for programmatic integrity and cost effectiveness. To the extent that any listed services are covered under the state plan, the services under the waiver would be limited to additional services not otherwise covered under the state plan, but consistent with waiver objectives of avoiding institutionalization.

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

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☒ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	DDSN/DSN Boards/Contracted Providers
Agency	Environmental Modification Providers

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Modifications

Provider Category:

Agency

Provider Type:

DDSN/DSN Boards/Contracted Providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The DSN Board or qualified provider may employ or contract with the following for consultation, assessment, and/or follow-up inspection; the provider is responsible to verifying and documenting licensure or certification:

- Contractor licensed by the South Carolina Department of Labor, Licensing and Regulation (LLR) not enrolled with SCDHHS as a DME provider
- Vendor with a retail or wholesale business license that is not enrolled with SCDHHS as a DME provider
- Licensed Occupational Therapist
- Licensed Physical Therapist
- Rehabilitation Engineering Technologist (RET) certified by Rehabilitation Engineering Society of North American (RESNA)
- Assistive Technology Practitioner (ATP) certified by Rehabilitation Engineering Society of North American (RESNA)
- ATP Supplier certified by Rehabilitation Engineering Society of North American (RESNA)
- Environmental Access Consultant/contractor certified by Professional Resources in Management (PRIME)

Verification of Provider Qualifications

Entity Responsible for Verification:

DDSN

Frequency of Verification:

Prior to service provision for each modification

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Modifications

Provider Category:

Agency

Provider Type:

Environmental Modification Providers

Provider Qualifications

License *(specify):*

Code of Laws, 1976 as amended 40-59-15 et seq

Certificate *(specify):*

Other Standard *(specify):*

Enrolled with DHHS

Verification of Provider Qualifications

Entity Responsible for Verification:

DHHS

Frequency of Verification:

Upon enrollment and at least every 18 months.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

In-Home Support services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08020 home health aide
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Care, supervision, teaching and/or assistance provided directly to or in support of the participant and provided in the participants 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:

Service Delivery Method *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [x] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Independent In-Home Support providers

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: In-Home Support services

Provider Category:

Individual

Provider Type:

Independent In-Home Support providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Must meet the following qualifications:
o Be at least 18 years of age.
o Have the ability to speak, read, and write English.
o Be capable of aiding in the activities of daily living.
o Be capable of following the Plan of Care with minimal supervision.
o Have no record of abuse, neglect, crimes committed against another or felonious conviction of any kind.
o Be free of communicable diseases.
o Possess a valid driver's license if required as part of the job.
o Other provider requirements include:
Settings must provide for the individual or his/her representative acknowledgment that the setting in which the service will be provided was chosen by them and has not been licensed, inspected or approved by DDSN or the contracted service provider.
a. The caregiver/respite provider must demonstrate competency by successful completion of exams designed to measure knowledge in the areas of: Confidentiality
b. Supervision
c. Prevention of abuse & neglect
d. First aid

Verification of Provider Qualifications

Entity Responsible for Verification:

DDSN Waiver Participant/Representative and DDSN Contracted Entity

Frequency of Verification:

Prior to service provision

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Personal Emergency Response Systems (PERS)

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14010 personal emergency response system (PERS)
Category 2:	**Sub-Category 2:**

Category 3: **Sub-Category 3:**

Service Definition *(Scope):*

Category 4: **Sub-Category 4:**

PERS is an electronic device which enables a participant who is at high risk of institutionalization to secure help in an emergency. The participant may wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals. PERS services are limited to those participants who live alone or are alone in their own home for three or more hours of the day/night and who would otherwise require supervision.

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

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☒ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Personal Emergency Response Provider (PERS)

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Emergency Response Systems (PERS)

Provider Category:

Agency

Provider Type:

Personal Emergency Response Provider (PERS)

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

1. FCC Part 68
2. Underwriters Laboratories (UL) and Equipment Testing Laboratories (ETL) approved as a "health care signaling product".
3. The product is registered with the FDA as a medical decide under the classification "powered environments control signaling product".

Verification of Provider Qualifications

Entity Responsible for Verification:

DHHS

Frequency of Verification:

Upon contract with DHHS

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Private Vehicle Assessment/Consultation

HCBS Taxonomy:

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

Service Definition *(Scope):*

Private vehicle assessment/consultation may be provided once a participant's specific need has been identified and documented in the Support Plan. The scope of the work and specifications must be determined. The criterion used in assessing a participant'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; or 2) the individual can drive but cannot get in or out of the vehicle and a modification to the vehicle would resolve the barrier.

Private vehicle assessment/consultation my include the specific modifications/equipment needed, any follow-up inspection after modifications are completed, training in use of equipment, repairs not covered by warranty, and replacement of parts or equipment.

The consultation /assessment does not require submission of bids.

Private Vehicle Assessments/Consultations can be completed by Licensed Medicaid enrolled Occupational or Physical Therapists, Medicaid enrolled Rehabilitation Engineering Technologists, Assistive Technology Practitioners and Assistive Technology Suppliers certified by the Rehabilitation Engineering Society of North American(RESNA), Medicaid enrolled Environmental Access/Consultants/Contractors certified by Professional Resource in Management Education(PRIME) or by vendors who are contracted through the DSN Board to provide the service.

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

The reimbursement for the consultation/assessment may not exceed $600.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	DDSN/DSN Board/Contracted Provider
Agency	DHHS Enrolled Providers

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Private Vehicle Assessment/Consultation

Provider Category:

Agency

Provider Type:

DDSN/DSN Board/Contracted Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The DSN Board or qualified provider may employ or contract with the following for consultation, assessment, and/or follow-up inspection; the provider is responsible for verifying and documenting licensure or certification:
- Licensed Occupational Therapist
- Licensed Physical Therapist
- Rehabilitation Engineering Technologist (RET) certified by Rehabilitation Engineering Society of North American (RESNA)
- Assistive Technology Practitioner (ATP) certified by Rehabilitation Engineering Society of North American (RESNA)
- ATP Supplier certified by Rehabilitation Engineering Society of North American (RESNA)
- Environmental Access Consultant/contractor certified by Professional Resources in Management (PRIME)

Verification of Provider Qualifications

Entity Responsible for Verification:

DDSN

Frequency of Verification:

Prior to service provision for each consultation

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Private Vehicle Assessment/Consultation

Provider Category:

Agency

Provider Type:

DHHS Enrolled Providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

DHHS enrolled provider

Verification of Provider Qualifications

Entity Responsible for Verification:

DHHS

Frequency of Verification:

Upon enrollment

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

PRIVATE VEHICLE MODIFICATIONS

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

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 for follow-up inspection after modifications are completed, training in the use of equipment, repairs not covered by warranty 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 recipients 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 recipients 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:

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☒ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	DHHS Enrolled Providers
Agency	DDSN/DSN Board/Contracted Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: PRIVATE VEHICLE MODIFICATIONS

Provider Category:

Agency

Provider Type:

DHHS Enrolled Providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Enrolled with DHHS

Verification of Provider Qualifications

Entity Responsible for Verification:

DHHS

Frequency of Verification:

Upon enrollment

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: PRIVATE VEHICLE MODIFICATIONS

Provider Category:

Agency

Provider Type:

DDSN/DSN Board/Contracted Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The DSN Board or qualified provider may employ or contract with the following for consultation, assessment, and/or follow-up inspection; the provider is responsible to verifying and documenting licensure or certification:

- Contractor licensed by the South Carolina Department of Labor, Licensing and Regulation (LLR) not enrolled with SCDHHS as a DME provider
- Vendor with a retail or wholesale business license that is not enrolled with SCDHHS as a DME provider
- Licensed Occupational Therapist
- Licensed Physical Therapist
- Rehabilitation Engineering Technologist (RET) certified by Rehabilitation Engineering Society of North American (RESNA)
- Assistive Technology Practitioner (ATP) certified by Rehabilitation Engineering Society of North American (RESNA)
- ATP Supplier certified by Rehabilitation Engineering Society of North American (RESNA)
- Environmental Access Consultant/contractor certified by Professional Resources in Management (PRIME)

Verification of Provider Qualifications

Entity Responsible for Verification:

DDSN

Frequency of Verification:

Prior to service provision for each modification

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

SUPPORT CENTER SERVICES

HCBS Taxonomy:

Category 1:	Sub-Category 1:
04 Day Services	04060 adult day services (social model)
Category 2:	**Sub-Category 2:**

Category 3: **Sub-Category 3:**

Service Definition *(Scope):*

Category 4: **Sub-Category 4:**

Non-medical care, supervision and assistance provided in a non-institutional, group setting outside of the participants 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 participants residence to the habilitation site when the service start time is before 12:00 Noon. Transportation will be available from the participants 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:

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☒ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	DDSN (Day Services Provider)

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: SUPPORT CENTER SERVICES

Provider Category:

Agency

Provider Type:

DDSN (Day Services Provider)

Provider Qualifications

License *(specify):*

SC Code Annotated § 44-20; 26 C Code Ann. Regs 88-105 thru 88-920 (1976)

Certificate *(specify):*

Other Standard *(specify):*

DDSN Standards for Support Center Services

Verification of Provider Qualifications

Entity Responsible for Verification:

DDSN

Frequency of Verification:

Initially; Annually; QIO Reviews are conducted on a 12-18 month cycle depending on past provider performance.

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

- ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.

  Check each that applies:

  - ☒ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
  - ☐ **As a Medicaid state plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
  - ☐ **As a Medicaid state plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
  - ☐ **As an administrative activity.** *Complete item C-1-c.*
  - ☐ **As a primary care case management system service under a concurrent managed care authority.** *Complete item C-1-c.*

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

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

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

- ○ **No. Criminal history and/or background investigations are not required.**

◉ **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

Direct care workers at Community Residential Care Facilities, Home Health Agencies, Personal Care Agencies, Adult Day Health Care Agencies, Nursing Homes providing respite, Waiver Case Managers and SCDDSN direct care staff are required to have following:

a. National federal fingerprint-based criminal background check if prospective employee cannot establish South Carolina residency for the 12 months preceding the date of the employment application and/or prospective employee will work with children under the age of 18.
b. South Carolina Law Enforcement Division (SLED) – not required if a. above is performed
c. DSS Child Abuse and Neglect Central Registry
d. Medicaid Exclusion List
e. Proof of current licensure as a SC Registered Nurse, if applicable
f. Nurse Registry, if applicable
g. Sex Offender Registry

Compliance reviews are conducted by DDSN's QIO and DHHS Provider Compliance to ensure mandatory investigations are conducted.

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

○ **No. The state does not conduct abuse registry screening.**

◉ **Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Nursing and Personal Care 2 Providers are required to check the Certified Nursing Assistant (CNA) registry and the Office of Inspector General (OIG) exclusions list for all staff. Anyone appearing on either of these lists is not allowed to provide services to waiver participants or participate in any Medicaid funded programs. The website addresses are:

CNA Registry - www.pearsonvue.com
OIG Exclusions List - http://www.oig.hhs.gov/fraud/exclusions.asp

SCDHHS Provider Compliance monitors contract compliance for Nursing providers, personal care providers, Adult Day Health Care providers, Adult Day Health Care Nursing providers and Adult Day Health Care Transportation providers. This occurs at least every eighteen months.

Additionally, abuse registry screenings must be completed for all staff of SCDDSN contracted service providers. The SC Department of Social Services maintains a Central Registry of persons convicted of abusing a child under the age of 18. All provider agency personnel must have a Central Registry Check. DDSNs policy, as indicated in Department Directive 406-04-DD, outlines the specific timelines that must be met. DDSN uses its QIO to monitor provider compliance with this policy.

Appendix C: Participant Services

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

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.**
- ( ) **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).**

Appendix C: Participant Services

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

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

- (●) **No. The state does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- ( ) **Yes. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) state policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the state ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the state policies specified here.*

- [ ] **Self-directed**
- [ ] **Agency-operated**

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

- ( ) **The state does not make payment to relatives/legal guardians for furnishing waiver services.**
- ( ) **The state makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

○ **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

◉ **Other policy.**

Specify:

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 spouse of a Medicaid participant;
3. A step-parent of a minor Medicaid participant;
4. A foster parent of a minor Medicaid participant; and,
5. Any other legally responsible guardian of a minor Medicaid participant
6. A court appointed guardian of an adult 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 following 2 websites:

http://www.scdhhs.gov
http://www.ddsn.sc.gov

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

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

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
NEW CS waiver providers meet the required licensing, certification, and other state standards prior to the provision of waiver services. N= Number of NEW CS waiver providers that meet the required licensing, certification and other state standards prior to the provision of waiver services; D= total number of NEW providers reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DHHS Provider Compliance 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**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:

	☒ **Other** Specify: 100% prior to contract/ enrollment	

Data Source (Select one):
Other
If 'Other' is selected, specify:
DDSN QIO Licensing 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**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Other
If 'Other' is selected, specify:
DDSN Behavior Support Provider 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: DDSN Contractor	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **Other** Specify: DDSN Contractor	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Existing CS waiver providers that continue to meet required licensing, certification, and other state standards. N= Number of existing CS waiver providers that continue to meet required licensing, certification and other state standards; D= total number of existing CS providers reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DHHS Provider Compliance 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**	☐ **Stratified** Describe Group:
	☒ **Continuously and**	☐ **Other**

	Ongoing	Specify:
	☒ **Other** Specify: 100% within 18 months	

Data Source (Select one):
Other
If 'Other' is selected, specify:
DDSN QIO Licensing 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: DDSN QIO	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Other
If 'Other' is selected, specify:
DDSN Behavior Support Provider 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: DDSN Contractor	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify: Periodic reviews to include all providers within a 4 year timeframe.	

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: DDSN Contractor	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
The proportion of Waiver Case Managers who meet required education and experience for employment. N = # of waiver case managers who meet the required education and experience; D = the # of waiver case managers reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
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: DDSN QIO Contractor	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify: QIO reviews are conducted every 12-18 months depending on past performance of the provider organization. Reports are available within 45 days post review.	

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: DDSN QIO Contractor	☒ **Annually**

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

Performance Measure:
New non-licensed/non-certified providers meet waiver requirements prior to the provision of waiver services. N = the number of new non-licensed/non-certified waiver providers that meet waiver requirements prior to the provision of waiver services. D = the total number of new non-licensed/non-certified individuals/entities who apply to become providers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DHHS Focus/Desk 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**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☒ **Other** Specify:

		Sampling determined by evidence warranting a special review.
	☒ **Other** Specify: As warranted.	

Data Source (Select one):
Other
If 'Other' is selected, specify:
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: DDSN QIO	☐ **Annually**	☒ **Stratified** Describe Group: Stratified Sampling Approach is based on the size of the provider.
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other**	

	Specify: DDSN QIO Reviews are conducted every 12-18 months based on past performance of the provider organization. Reports are available 45 days post review.	

Data Source (Select one):
Other
If 'Other' is selected, specify:
DHHS Provider Compliance 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**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Existing non-licensed/non-certified CS providers continue to meet waiver requirements. N = number of existing non-licensed/non-certified waiver providers that meet waiver requirements. D = total number of existing non-licensed/non-certified providers reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DHHS Focus/Desk 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**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☒ **Other** Specify: Sampling determined by evidence warranting a special review.
	☒ **Other** Specify: As warranted	

Data Source (Select one):
Other
If 'Other' is selected, specify:
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**	☒ **Stratified** Describe Group:

DSN QIO COntractor		Stratified Sampling Approach is based on the size of the provider.
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify: DDSN QIO Reviews are conducted every 12-18 months based on past performance of the provider organization. Reports are available 45 days post-review.	

Data Source (Select one):
Other
If 'Other' is selected, specify:
DHHS Provider Compliance 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**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify: 100% within 18 months	

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: DDSN QIO Contractor	☒ **Annually**
	☐ **Continuously and Ongoing**
	☒ **Other** Specify:

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

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
CS waiver providers meet training requirements by provider type as specified by the State's scope of service of other operational directive. N= Number of CS waiver providers who meet training requirements; D= total number of providers reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
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: DDSN QIO Contractor	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify: DDSN QIO Reviews are conducted every 12-18 months depending on past provider performance. Reports are available within 45 days post review.	

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: DDSN QIO	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States 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.

Information about agencies that were reviewed, compliance issues uncovered, and corrections made will be maintained along with timeframes of correction.

DDSN will share this information with DHHS on an on-going basis as reports are received from the QIO and/or the contracting agency.

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**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
DDSN QIO Contractor	
	☐ **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.

◉ **No**

○ **Yes**

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

◉ **Not applicable**- The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

○ **Applicable** - The state imposes additional limits on the amount of waiver services.

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

☐ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

☐ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

☐ **Other Type of Limit.** The state employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.
2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

SCDHHS is in the process of determining if our settings are in compliance by completing a policies and standards review for our settings. This will be followed-up by conducting facility self-assessments and site visits all of which is detailed in the waiver transition plan. In December 2016 the State awarded a Request for Proposal (RFP) to begin conducting the day program HCBS site assessments to determine settings compliance with Final Rule Requirements.

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:

Service Plan

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

☐ **Registered nurse, licensed to practice in the state**

☐ **Licensed practical or vocational nurse, acting within the scope of practice under state law**

☐ **Licensed physician (M.D. or D.O)**

☒ **Case Manager** (qualifications specified in Appendix C-1/C-3)

☐ **Case Manager** (qualifications not specified in Appendix C-1/C-3).
Specify qualifications:

☐ **Social Worker**
Specify qualifications:

☐ **Other**
Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

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

○ **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**

◉ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The state has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

To comply with the conflict of interest regulation at (42 CFR 441.301(c)(1)(vi)), the South Carolina Department of Health and Human Services (SCDHHS) created a compliance transition plan that will prevent a conflict of interest between case management and direct service provision that currently exists with Disabilities and Special Needs (DSN) Board providers. Over the next three years, SCDHHS and South Carolina Department of Disabilities and Special Needs (SCDDSN) will work with providers to transition waiver participants receiving both case management and direct services from the same provider into a conflict-free service provision environment. This will include appropriate policy changes, technical assistance for providers and ongoing support for waiver participants during the transition. The transition will be complete on or before Dec. 31, 2023.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

DHHS, DDSN and case management providers are continuously improving their understanding and implementation of the principles of person-centered planning (PCP). PCP as a framework helps guide case managers to the most effective services and supports; ensures participants direct and are actively engaged in the process; and, encourages involvement of other people chosen and/or approved by the participant including friends, relatives, providers, members of the community, etc. The resulting plan is a valuable document written in plain language.

More specifically, the person-centered service plan focuses on the participant's goals and aspirations for a lifestyle that promotes dignity, respect, interdependence, education, employment, community participation, wellness and relationship opportunities. PCP encourages the use of natural and community supports as well as the creation of plans that view participants in the context of their culture. All of the elements that compose a participant's individuality and a family's uniqueness are acknowledged and valued in the planning process. PCP supports mutually respectful partnerships between participants and providers/professionals.

The participant signs the service plan indicating agreement with the services and supports detailed and confirmation of choice of qualified service providers.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

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

The person centered Service Plan is directed by the participant/representative and developed by the WCM qualified provider based on the comprehensive assessment of the waiver participant's strengths, needs, and personal priorities (goals) and preferences. The participant/representative, family, legal guardian, caregivers, professional service providers (including physicians) and others of the participant's choosing may provide input. Service Plans are individualized for each waiver participant, stressing the importance of community support. An initial Service Plan is developed within 60 days of waiver enrollment, updated as needed, and a new Service Plan is completed within 365 days.

Participants/representative 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 WCM qualified provider has identified the need for the service.

Participation in the planning process (assessment, plan development, implementation) by the participant/representative, , knowledgeable professionals and others of the participant/representative's choosing, helps to assure that the participant's personal priorities and preferences are recognized and addressed by the person-centered Service Plan. All needs identified during the assessment process must be addressed. As part of the Service Plan development process, it is determined if the participant has health care needs that require consistent, coordinated care by a physician, therapist, or other health care professionals. The WCM qualified provider must utilize information about the participant's strengths, priorities and preferences to determine how those needs (to include health care needs) will be addressed. The Service Plan will include a statement of the participant's need; 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 WCM qualified provider will have primarily responsibility for coordinating services but must rely on the participant/representative to choose a service provider from among those available, avail him/herself for, and honor appointments that are scheduled with providers when needed for initial service implementation and ongoing monitoring of services. The appointments must be of convenient times and locations to the participant in order to coordinate an effort of collaborative cooperation with all parties who are involved with the development and ongoing monitoring of the Service Plan.

WCM providers are responsible for locating and coordinating other community or State Plan services. The objectives of waiver case management are to counsel, support and assist participants/families with all activities related to the CS waiver program. WCM providers must provide ongoing problem solving to address participant/family needs. They must coordinate community-based support, provide referrals to other agencies and participate in interagency case staff meetings as needed. These activities must be fully documented in the participant's waiver record.

Changes to the Service Plan will be made as needed by the WCM provider when the results of monitoring or when information obtained from the participant/representative, and/or service providers indicates the need for a change to the Service Plan.

Every calendar month the WCM provider will contact the participant/representative to conduct monitoring of the Service Plan or waiver services/other services. Non face-face contacts are required during months in which a face-to-face contact is not conducted. Based on the results of the monitoring, amendments may be needed to the Service Plan.

On at least a quarterly basis the WCM provider will conduct a face to face contact with the participant/representative during which the effectiveness of the Service Plan will be discussed along with the participant's/representative's satisfaction with the services/providers. Every six months, the WCM provider will visit the participant in the home/residence to monitor the health and welfare of the participant.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

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

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

A standardized assessment tool is used for all waiver participants. This tool assesses the person's current situation, health and safety risk factors, and his/her personal preferences. The plan of service document includes sections that outline the responsibilities of the waiver participant/representative, and the responsibilities of the WCM. The WCM/EI provider agency also conducts training with staff annually to review proper reporting procedures for abuse, neglect, exploitation, and unexplained deaths.

Additionally, WCM/EI providers will encourage parents/representative/responsible parties to make back-up plans for emergencies when they take vacations or are away from home for extended periods of time.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

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

Upon request or as service needs change, participants, families, legal guardians and/or representatives are given a list of providers of specified waiver services for which a change is requested or needed in order to select a provider. This list includes phone numbers. They 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. Lists are also available on the DDSN website.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

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

The format and content of the questions for the service plan document, as well as, the intended planning process must be reviewed and approved by DHHS prior to implementation. Participant plans are available upon request.

In addition, DHHS QA reviews service plans on an annual basis. Providers are informed of required corrective actions based on these reviews.

The State incorporates quality assurance/quality improvement activities into waiver administration and waiver operation. Both DHHS and DDSN contract with (different) CMS-approved Quality Improvement Organizations (QIO) to conduct quality functions. DDSN uses their QIO to perform provider and participant record reviews by making on-site visits, interviewing consumers and staff, and making observations to ensure services are implemented based on assessed need. In addition, the provider's administrative capabilities are reviewed to ensure compliance with DDSN standards, contracts, policies, and procedures. Any deficiencies require a written Plan of Correction (POC) within 30 days that addresses the deficiency both individually and systemically. A follow-up review is conducted approximately six (6) months after the original review to ensure successful remediation and implementation of the POC.

DHHS conducts a "look-behind" review of provider records that were reviewed by the DDSN QIO. This consists of a small sample designed to verify agreement or disagreement with the QIO findings. Included in this review are contract compliance indicators that relate to the service plan. Findings are summarized and issued to DDSN and the provider.

Appendix D: Participant-Centered Planning and Service Delivery

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

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

- ○ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**
- ○ **Every twelve months or more frequently when necessary**
- ◉ **Other schedule**

Specify the other schedule:

Updated at least annually (within at least every 365 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:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

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

The waiver case manager is primarily responsible for monitoring the implementation of the service plan and participant health and welfare. DHHS and DDSN perform oversight activities to ensure case management providers are meeting the State's expectations in this area.

Monitoring and follow up methods include the following:
- Waiver case manager explains the participant's right to freedom of choice when it comes to selecting a provider for services. A list of qualified providers is readily available and the WCM will assist the participant in contacting any provider as needed.

- DDSN staff review all service plans prior to implementation. In addition to ensuring the plans are effectively addressing the needs of the participants, DDSN staff check for compliance with policy.

- At a minimum, the waiver case manager makes contact with the participant and/or representative monthly to determine whether services are meeting the participants' needs and are continuing to be effective. If services are not meeting the needs of the participant, additional assessments will be conducted and the plan revised to address the need. Waiver case managers may also make referrals for and monitor non-waiver services (such as medical appointments or food pantry) as necessary to ensure that participants' needs are met as a whole .

Quarterly, the case manager makes a face-to-face contact with the participant/representative. Annually, or more often if necessary, a new service plan is developed by the case manager in consultation with the participant/representative.

- As issues arise, waiver case managers work with the participant/representative and service providers to have them addressed. If the issue rises to the level that the case manager is unable to resolve, the waiver administrators at DDSN are contacted for assistance. DHHS waiver administrators are further contacted if issues arise surrounding policy or compliance. Appropriate reports are made in instances of ANE or any other circumstance that policy dictates. Monitoring and follow-up actions are documented in activity notes in the participant's record. Monitoring and follow-up actions are reviewed as part of quality assurance activities carried out by DHHS and/or DDSN. When necessary, DHHS and/or DDSN require case management providers to execute corrective actions.

- DHHS and/or DDSN quality assurance and licensing programs measure compliance with indicators related to health and welfare, approve required plans of correction, and conduct follow-up reviews to ensure successful remediation.

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:*

The following monitoring safeguards are employed in addition to those described in D-2a:

DDSN monitors allegations of abuse, neglect and exploitation (ANE) and other critical incidents (CI). As part of its activities, DDSN tracks the reporting process, requires corrective actions, ensures remediation has taken place, and provides technical assistance regarding prevention.

Participants must be given free choice of provider for any service. DDSN's QIO conducts reviews of service plans to ensure compliance, approves all required plans of correction, and conducts a follow-up review to ensure successful remediation.

DDSN maintains an electronic documentation system in which the assessments and service plans are completed. The system ensures the user completes the assessment consistent with policy. Once completed, a decision is required whether or not to formally address each need as identified by the assessment. The phrase "to formally address" means the need is included in the service plan and the services/interventions are in response to the need and are authorized. The decision is made by the participant and those chosen by the participant to assist in the planning.

DDSN staff review all service plans prior to implementation. In addition to ensuring the plans are effectively addressing the needs of the participants, DDSN staff check for compliance with policy.

DDSN's QIO performs reviews on a regular basis. For each finding noted in a QIO report, the provider is required to submit a plan of correction to the QIO. The QIO then conducts a follow-up review approximately six months later to ensure successful implementation of the plan of correction. The plan of correction addresses remediation at the individual level, and when warranted, includes a systems review and aggregated remediation. To ensure prompt follow up on identified problems, DDSN begins monitoring remediation activities shortly after receiving a provider's QIO report.

DDSN also monitors QIO reports to identify system-wide issues that require training, technical assistance, and/or policy changes. Systemic issues are communicated to the provider network in an effort to collect input, provide guidance, and reduce overall citations. These issues are addressed through quarterly counterpart meetings attended by DDSN personnel. Policy revisions are implemented in collaboration with providers and after receipt of public input. Current and proposed DDSN Directives and Standards are available to the public for review at any time on the DDSN Web-site. Information derived from monitoring is compiled and reported to the State.

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

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

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

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

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

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

Performance Measure:
Person Centered Plans for CS waiver participants include services, supports and goals that are consistent with assessed needs. N= Number of CS waiver participant plans reviewed that include services, supports and goals consistent with assessed needs; D= total number of CS waiver files reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
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: DDSN QIO Contractor	☐ **Annually**	☒ **Stratified** Describe Group: Stratified Sampling Approach is based on the size of the provider.
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify:	

	DDSN QIO reviews are conducted on a 12-18 month cycle based on past performance of the provider.	

Data Source (Select one):
Other
If 'Other' is selected, specify:
DHHS Focus/Desk 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**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☒ **Other** Specify: As Warranted
	☒ **Other** Specify: As warranted	

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: DDSN QIO Contractor	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

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

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
Person Centered Plans for CS waiver participants are developed at least annually and revised when warranted by a change in participants needs. N= Number of CS waiver participants whose person centered plans were developed at least annually and

revised when warranted by a change in the participants needs; D= total number of CS waiver files reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
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: DDSN QIO Contractor	☐ **Annually**	☒ **Stratified** Describe Group: Stratified Sampling Approach is based on the size of the provider.
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify:	

	DDSN QIO Reviews are conducted on a 12-18 month cycle depending on past performance of the provider organization. Reports are available within 45 days post review.	

Data Source (Select one):
Other
If 'Other' is selected, specify:
DHHS Focus/Desk 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**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☒ **Other** Specify: Sampling determined by evidence warranting a special review.
	☒ **Other** Specify:	

	As warranted	

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: DDSN QIO Contractor	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
The Waiver Case Manager must complete two (2) quarterly face to face visits with the participant in the home/residence during each PLAN year per policy. N = the # of completed quarterly face-to-face visits in the home/residence; D = the total # of completed quarterly face-to-face visits.

Data Source (Select one):
Other
If 'Other' is selected, specify:
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: DDSN QIO Contractor	☐ **Annually**	☒ **Stratified** Describe Group: Stratified Sampling Approach is based on the size of the provider.
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify: DDSN QIO Reviews are conducted on a 12-18 month cycle depending on past performance of the provider organization. Reports are available 45 days post review.	

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: DDSN QIO Contractor	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
The Waiver Case Manager must complete four (4) quarterly face-to-face visits with the participant each year of the Individual's PLAN per policy. N = the # of completed quarterly face-to-face visits; D = the total # of face-to-face visits required.

Data Source (Select one):
Other
If 'Other' is selected, specify:
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**	☒ **Stratified** Describe Group:

DDSN QIO Contractor		Stratified Sampling Approach is based on the size of the provider.
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify: DDSN QIO reviews are conducted on a 12-18 month cycle depending on past performance of the provider organization. Reports are available within 45 days post review.	

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: DDSN QIO Contractor	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
The Waiver Case Manager must complete the required non face-to-face contact each month with the waiver participant/family per policy. N = The # of non face-to-face contacts completed; D = the # of all non face-to-face contacts required.

Data Source (Select one):
Other
If 'Other' is selected, specify:
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: DDSN QIO Contractor	☐ **Annually**	☒ **Stratified** Describe Group: Stratified Sampling Approach is based on the size of the provider.
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify:	

	DDSN QIO reviews are conducted on a 12-18 month cycle depending on past performance of the provider organization. Reports are available within 45 days post review.	

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: DDSN QIO Contractor	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Participants receive services and supports in the type, scope, amount, frequency and duration as specified in their Person Centered Plan and in accordance with CS waiver policy. N= Number of CS waiver participants who are receiving services and supports in the type, scope, amount, frequency and duration as specified in the plan; D= total number of CS waiver files reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
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: DDSN QIO Contractor	☐ **Annually**	☒ **Stratified** Describe Group: Stratified Sampling Approach is based on the size of the provider.
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify: DDSN QIO reviews are conducted on a 12-18 month cycle bases on past performance of the provider.	

Data Source (Select one):
Other
If 'Other' is selected, specify:
DHHS Focus/Desk 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**	☒ **Stratified** Describe Group: Stratified Sampling Approach is based on the size of the provider.
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify: As warranted	

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: DDSN QIO Contractor	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other**

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

e. ***Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
Community Support Waiver participants are offered choice of qualified providers.
N= Number of CS waiver participants who were offered choice of qualified providers; D= total number of CS waiver files reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DDSN QIO 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**	☒ **Stratified** Describe Group:

DDSN QIO Contractor		Stratified Sampling Approach is based on the size of the provider.
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☒ **Other** Specify: DDSN QIO Reviews are conducted on a 12-18 month cycle depending on past performance of the provider organization. Reports are available within 45 days post review.	

Data Source (Select one):
Other
If 'Other' is selected, specify:
DHHS Focus/Desk 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**	☐ **Annually**	☐ **Stratified**

Specify:		Describe Group:
	☐ **Continuously and Ongoing**	☒ **Other** Specify: Sampling determined by evidence warranting a special review.
	☒ **Other** Specify: As warranted	

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: DDSN QIO Contractor	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information

regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

When DDSN's QIO identifies problems, the provider is required to submit a plan of correction to address the non-compliance issues. The QIO conducts a follow-up review to determine if the problems have been corrected. Additionally, QIO reports are reviewed by DDSN Operations staff. As needed, technical assistance is provided to providers by the Operations staff. Documentation of all technical assistance is available. DDSN QIO reviews, provider plans of correction and QIO follow-up review results are available to DHHS.

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: DDSN QIO Contractor	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

◉ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.

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

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

direction.

Indicate whether Independence Plus designation is requested *(select one):*

- ○ **Yes. The state requests that this waiver be considered for Independence Plus designation.**
- ◉ **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

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

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

Waiver case managers 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 waiver case manager 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 waiver case manager will continue to monitor service delivery and the status of the participants health and safety.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

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

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

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

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

  Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

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

- ○ **Waiver is designed to support only individuals who want to direct their services.**
- ○ **The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**
- ◉ **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the state. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

The participant or responsible party (RP) must have no communication or cognitive deficits that would interfere with participant or RP direction. The WCM/EI provider will assess and determine if these criteria are met. Participants interested in self-directed care are pre-screened to assure capability utilizing a standardized pre-screen form. The pre-screening form utilized is standardized across waiver programs and assesses three main areas of ability that are critical to self-direction and assuring the health and welfare of the participant.

These include: communication, cognition patterns, and mood and behavior patterns. The communication section assesses the ability of the participant/RP to make themselves understood and the ability of others to understand the participant/RP. The cognitive patterns section evaluates both the short-term memory and cognitive skills for daily decision making of the participant/RP. Finally, the assessment tool reviews the mood and behavior patterns of the participant/RP to assess sad/anxious moods. The assessment is scored based on these three areas and the results are shared with the participant/RP. If the participant/RP disagrees with the results they may appeal the decision. The RN match visit is completed prior to service authorization.

WCM/EI providers assess the cognitive and communication abilities of participants/family members who wish to direct some of their waiver services. This process is consistent for all waiver participants meeting the ICF/IID Level of Care. If self-directed or family-directed attendant care is not an appropriate option, the participant is referred to (agency provided) personal care services.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

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

At the time of the initial assessment, the waiver case manager will introduce participant direction of In-Home Support and provide information about this option. The waiver case manager will provide this information initially or at the request of the participant/representative. If the participant/representative is interested the waiver case manager will provide more details about the benefits and responsibilities of participant direction and determine continued interest. The waiver case manager will provide extensive information about the benefits as well as the risks, responsibilities and liabilities of participant/representative direction.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

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

○ **The state does not provide for the direction of waiver services by a representative.**

◉ **The state provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

☒ **Waiver services may be directed by a legal representative of the participant.**

☒ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.** Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

A participant may choose to have waiver services directed by a representative 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 participants care. The chosen representative must demonstrate a strong personal commitment to the participant and knowledge of the participants 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.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
In-Home Support services	☒	☐

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

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

◉ **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i)*.

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

☒ **Governmental entities**

☒ **Private entities**

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

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

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

○ **FMS are covered as the waiver service specified in Appendix C-1/C-3**

The waiver service entitled:

◉ **FMS are provided as an administrative activity.**

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

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 participants/representatives 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.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

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

☒ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

Waiver case managers 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 waiver case manager 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 waiver case manager will continue to monitor service delivery and the status of the participants health and safety.

☒ **Waiver Service Coverage.**

Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Waiver Case Management (WCM)	☐
Adult Day Health Care Services	☐

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
In-Home Support services	☒
BEHAVIOR SUPPORT SERVICES	☐
Assistive Technology and Appliances	☐
Adult Day Health Care Transportation	☐
Assistive Technology and Appliances Assessment/Consultation	☐
PRIVATE VEHICLE MODIFICATIONS	☐
Personal Emergency Response Systems (PERS)	☐
CAREER PREPARATION SERVICES	☐
Adult Day Health Care Nursing	☐
Incontinence Supplies	☐
Private Vehicle Assessment/Consultation	☐
Environmental Modifications	☐
Respite Care Services	☐
COMMUNITY SERVICES	☐
SUPPORT CENTER SERVICES	☐
DAY ACTIVITY	☐
EMPLOYMENT SERVICES	☐
Personal Care Services	☐

☒ **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.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one).*

○ **No. Arrangements have not been made for independent advocacy.**

◉ **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

The Center for Disability Resources at the University of South Carolina. This advocacy is accessed through the Service Coordinator.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

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

The waiver case manager will accommodate the participant by providing a list of feasible alternatives and other qualified service providers from which a provider can be selected in order to maintain service delivery. The waiver case manager and DDSN staff 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.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

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

If through regular monitoring questions arise about the health, safety, and welfare of a participant who receives In-Home Support, the waiver case manager will utilize the standardized assessment to re-assess the participants/representatives ability to direct the service. When results of the assessment indicate an inability by the participant or representative to direct the In-Home Support services and a Human Rights Committee concurs, the waiver case manager will initiate the transition from the participant/representative-directed services to agency-directed services based on need. The waiver case manager will update the plan of service to include any necessary measures to be taken until the transition is completed.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

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

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1	50	
Year 2	100	
Year 3	150	

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	Number of Participants	Number of Participants
Year 4	150	
Year 5	150	

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

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

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both*:

☐ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

☒ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

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

☒ **Recruit staff**
☐ **Refer staff to agency for hiring (co-employer)**
☒ **Select staff from worker registry**
☒ **Hire staff common law employer**
☒ **Verify staff qualifications**
☒ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

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-1/C-3.**

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

- [x] **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**
- [ ] **Determine staff wages and benefits subject to state limits**
- [x] **Schedule staff**
- [x] **Orient and instruct staff in duties**
- [x] **Supervise staff**
- [x] **Evaluate staff performance**
- [x] **Verify time worked by staff and approve time sheets**
- [x] **Discharge staff (common law employer)**
- [ ] **Discharge staff from providing services (co-employer)**
- [ ] **Other**

Specify:

Appendix E: Participant Direction of Services

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

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

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

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

- [ ] **Reallocate funds among services included in the budget**
- [ ] **Determine the amount paid for services within the state's established limits**
- [ ] **Substitute service providers**
- [ ] **Schedule the provision of services**
- [ ] **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
- [ ] **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
- [ ] **Identify service providers and refer for provider enrollment**
- [ ] **Authorize payment for waiver goods and services**
- [ ] **Review and approve provider invoices for services rendered**
- [ ] **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

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

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

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

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

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

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

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

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

- ○ **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- ○ **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

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

b. Participant - Budget Authority

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

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

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

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

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

The Waiver participant or the parents/legal guardian of the Waiver participant is informed 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:

The South Carolina Department of Disabilities and Special Needs (SCDDSN) is responsible for the day-to-day operations of the Intellectual Disability-Related Disabilities (ID-RD) Waiver, the Community Supports (CS) Waiver, the Head and Spinal Cord Injury (HASCI) Waiver, and the Pervasive Developmental Disorder (PDD) Waiver. If a Waiver participant disagrees with a decision made and/or action taken by SCDDSN, reconsideration and reversal of the adverse decision/action may be requested.

The SCDDSN reconsideration process must be completed in its entirety before seeking an appeal with the South Carolina Department of Health and Human Services (SCDHHS), which is the State Medicaid Agency.

A request for a SCDDSN reconsideration of an adverse decision/action must be made in writing within thirty (30) calendar days of receipt of written notification of the adverse decision/action. The request must clearly state the basis of the complaint, previous efforts to resolve the complaint, and relief sought. If the adverse decision/action was in response to a request to exceed service limits, evidence of the medical necessity of the services must be included in the request and will be considered by SCDDSN. If necessary, a Case Manager or other staff may assist the participant, legal guardian or representative in requesting reconsideration. The request must be dated and signed by the participant, legal guardian or representative assisting the participant. The request for reconsideration must be mailed to:

State Director
SC Department of Disabilities and Special Needs
P.O. Box 4706
Columbia, SC 29240

The State Director or a designee will issue a written decision within ten (10) working days of receipt of the written reconsideration request and mail it to the participant, legal guardian or representative. If the State Director upholds the original adverse action/decision, the reason(s) shall be specifically identified in the written notification.

Note: In order for affected Waiver services to continue during the SCDDSN reconsideration process and the SCDHHS Medicaid appeal process, the participant, legal guardian or representative's request for SCDDSN reconsideration must be submitted within ten (10) calendar days of receipt of written notification of the adverse decision/action. Continuation of the affected Waiver services must be specifically requested in the request for SCDDSN reconsideration. If the adverse decision/action is upheld, the participant or legal guardian may be required to repay the cost of affected Waiver services received during the time of the reconsideration/appeal processes.

SCDHHS MEDICAID APPEAL PROCESS

If the participant, legal guardian or representative fully completes the SCDDSN reconsideration process above and is dissatisfied with the result, the participant, legal guardian or representative has the right to request an appeal with the State Medicaid Agency, which is the South Carolina Department of Health and Human Services (SCDHHS).
The appeal request may be made electronically using the SCDHHS website indicated below or it may be mailed to SCDHHS. This must be done no later than thirty (30) calendar days after receipt of the SCDDSN notification.

The purpose of a SCDHHS administrative appeal is to prove error(s) in fact or law pertaining to a decision made and/or action taken by SCDDSN that adversely affects a Waiver participant. The appeal must clearly state the specific issue(s) that are disputed and what action is requested. A copy of the reconsideration notification received from SCDDSN must be uploaded using the SCDHHS website indicated below or included with the mailed appeal.

The, participant, legal guardian or representative is encouraged to file the appeal electronically at www.scdhhs.gov/appeals.
OR
The appeal request may be mailed to:

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

An appeal request to SCDHHS is valid if filed electronically or mailed to the above address and postmarked no later than the thirtieth (30th) calendar day following receipt of the SCDDSN reconsideration notification. Unless a valid appeal request is made to SCDHHS, the SCDDSN reconsideration decision will be final and binding.

If a valid appeal request is made, the participant, legal guardian or representative will be advised by the SCDHHS Division of Appeals and Hearings as to the status of the appeal request, which may include a scheduled hearing.

A beneficiary may request an expedited appeal. SCDHHS will grant or deny these requests as quickly as possible. If we grant your request to expedite, your appeal will be resolved as quickly as possible instead of the standard 90-day timeframe. If we deny the request to expedite, the appeal will follow the standard 90-day timeframe.

SCDHHS may grant expedited review if we determine the standard appeal timeframe could jeopardize the individual's life, health, or ability to attain, maintain, or regain maximum function. SCDHHS may consider, among other facts:

- the medical urgency of the beneficiary's situation
- whether a needed procedure has already been scheduled
- whether a beneficiary is unable to schedule a needed procedure due to lack of coverage
- whether other insurance will cover most of the costs of the requested treatment.

You may request an expedited appeal at the same time you file your appeal request or after you file an appeal. Please state you are requesting an expedited appeal and explain why.

To avoid delays in the process, please submit any supporting documentation with the request for expedited review or immediately thereafter. While supporting documentation is not required, SCDHHS will make its determination based on the information made available at the time we consider the request.

Copies of notices of adverse actions, decisions, and opportunities to request a fair hearing are kept in the participant's file.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

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

- (●) **No. This Appendix does not apply**
- ( ) **Yes. The state operates an additional dispute resolution process**

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: Participant-Rights

Appendix F-3: State Grievance/Complaint System

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

- ( ) **No. This Appendix does not apply**
- (●) **Yes. The state operates a grievance/complaint system that affords participants the opportunity to register**

grievances or complaints concerning the provision of services under this waiver

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

DDSN operates the Complaint/Grievance system

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 requires that all DSN Boards and contracted providers have established procedures to assure consumer concerns are listened to and handled appropriately. The types of concerns handled through this process are issues that do not rise to the level of critical incidents, ANE, or waiver matters that would normally follow the reconsideration/appeal process. People are encouraged to first seek remediation through their local service provider where all efforts will be made to resolve concerns at the most immediate staff level. If the concern cannot be resolved at the provider level, the matter is referred to the DDSN Office of Consumer Affairs or the appropriate District Director. Follow-up to a concern reported to the DDSN Office of Consumer Affairs or District Director will include contact with the person or representative expressing the concern, review and research of the concern, efforts to mediate resolution, and documentation of all actions taken. The nature of the concern and the needs of the individual factor into the time period required for response, but generally all responses with feedback to the complainant are provided within 10 business days. Concerns involving health and safety of people receiving services will receive immediate, same day review and necessary action will be taken if the person's health or safety is at risk.

The participant shall be informed in all circumstances that filing a grievance or making a complaint is not a pre-requisite or substitute for a fair hearing.

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 requires the reporting and investigating of suspected abuse, neglect and exploitation (ANE) of a vulnerable child (under the age of eighteen) to the Department of Social Services (DSS)/Child Protective Services (CPS) and local and state law enforcement. The South Carolina Omnibus Adult Protection Act requires the reporting and investigating of suspected ANE of a vulnerable adult (age 18 and above) to DSS/Adult Protective Services (APS) and local and state law enforcement. 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 ANE. Mandated reporters are defined as professional staff, employees, and volunteers or contract provider agencies having a legal responsibility under state law to report suspected ANE to state investigative agencies. Mandated reporters must make the report within 24 hours or the next business day after discovery of the ANE. All DDSN staff are required to have annual competency based training on mandated reporting responsibilities and reporting channels. This is outlined in DDSN Directive 543-02-DD. It is part of the agency's pre-service and annual training requirements and is monitored through the QIO process.

In addition, DDSN Directive 534-02-DD specifically addresses the procedures for preventing and responding to ANE. This directive sets the reporting requirements of state law and also identifies DDSN and its contract provider agencies' legal responsibility for reporting ANE. The directive also identifies the appropriate state investigative agencies with statutory authority to receive and investigate reports of suspected ANE and identifies the administrative and management functions of DDSN and its network of contracted service providers.

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 SCDDSN Regional Center, DSN Board facility, other service provider facility, or during the provision of waiver case management services. 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.

In order to coordinate the process of reviewing all reports, DDSN has implemented a secure, web-based Incident Management System (IMS) which contains three different modules: ANE reporting, Critical Incident reporting, and Death reporting. The applicable DDSN Directives govern the reporting process, but the IMS provides a mechanism for processing the reports. In some cases, a provider may make a verbal notification to the District Director, but a report on the IMS is required within 24 hours, or the next business day.

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 waiver case managers. The State requires documentation in the participant's record to verify this was completed. The QIO monitors for compliance.

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.

DDSN Directives 100-09-DD and 534-02-DD require the service provider to make an initial report of the incident within 24 hours or the next business day. The providers must then complete an internal review of the incident within 10 working days. The internal review is submitted to DDSN for acceptance by the Statewide Incident Management Coordinator. DDSN policies require the provider, upon completion of the internal review, to notify the participant and/or responsible party of the outcome of the review. The Case Management Provider is also informed in order to ensure that any health and safety concerns are addressed. DDSN Directives 534-02-DD and 100-09-DD set forth the reporting requirements of state law and also specifically address the procedures for preventing, responding, and reporting critical incidents and ANE. These directives also identify the appropriate state investigative agencies with statutory authority to receive and investigate reports of suspected ANE. Further, the Directives outline the administrative and management functions of DDSN and its network of contracted providers.

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 ANE in these settings. DDSN and its contract provider agencies shall be available to provide information and assistance to DSS. Procedures have been established for DDSN 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, a contract provider agency, or the family and ANE 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 applicable critical incidents and/or ANE allegations.

Incidents that do not meet the threshold for reporting under Directives 100-09-DD or 534-02-DD are captured under DDSN Directive 535-08-DD, Concerns of People Who Receive Services: Reporting and Resolution. All providers have a procedure for people who receive services and supports or representatives acting in their behalf that assures their right to voice concerns without actions being taken against them for doing so. The procedure delineates all steps in the process. Support may be provided, if needed, to people who wish to express a concern but need assistance in understanding or following the process. All efforts are made to resolve concerns at the most immediate staff level that can properly address the concern. Concerns involving health and safety of people receiving services receive immediate review and necessary action is taken if the persons health or safety is at risk.

On a regular basis, DDSN Quality Management staff review critical incidents and ANE reports, 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, as addressed in Directive 100-28-DD. Each regional center, DDSN 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. Statewide trend data and training curriculum will be provided to DHHS on an annual basis.

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.

The DDSN Critical Incident and ANE directives set forth the reporting requirements of state law and also identify DDSN and its contract provider agencies' legal responsibility for reporting ANE. The directive, 100-09-DD, also identifies the appropriate state investigative agencies with statutory authority to receive and investigate reports of suspected ANE and identifies the administrative and management functions of DDSN and its network of contracted service providers. DHHS receives and reviews reports provided by DDSN regarding the state agencies/offices who have statutory authority to conduct investigations.

DSS Child Protective Services and local and state law enforcement are responsible for overseeing the reporting of and response to allegations of ANE. In addition to investigations by the State Ombudsman, DSS, and law enforcement, other agencies have jurisdiction to make inquiry into incidents of ANE 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.

Vulnerable Adult Fatalities Review Office
The Vulnerable Adult Fatalities (VAF) Review Office of the State Law Enforcement Division (SLED) will investigate all deaths involving abuse, physical and sexual trauma, as well as, suspicious and questionable deaths of vulnerable adults. The State Vulnerable Adult Investigations Unit (VAIU) will also review the involvement that various agencies may have had with the person prior to death.

In addition, the DDSN Division of Quality Management maintains information on the incidence of ANE, 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 ANE 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. All findings from trending analysis will be shared with DHHS on an annual basis.

Per DDSN Directive 100-09-DD, DDSN requires that each contracted provider agency complete a Management Review for each report of a Critical Incident. This includes a safety plan for the service recipient, in addition to a review of any preventive measures that may be taken through the agency's quality assurance plan. Each provider is also required to have a Risk Management Committee that reviews data on individual Critical Incidents and tracks, trends, and analyzes system wide issues.

For allegations of Abuse, Neglect, and Exploitation, per DDSN Directive 534-02-DD, each contracted provider agency is required to complete an Administrative Review. In all allegations of ANE, the alleged perpetrator must be immediately placed on Administrative Leave without Pay and all allegations are reported to a State Investigative Agency. (ANE Allegations, by SC Law, are not investigated by DDSN.) The provider agency may conduct an internal review for policy or procedure violations, but they cannot complete an investigation for ANE.

DDSN has recently hired (February 2017) a Risk Management Coordinator that will be completing a secondary review of ANE Allegations and Critical Incidents where there have been significant negative outcomes to a person supported by the agency.

DDSN State Office reviews each and every Critical Incident Report and Allegation of ANE. DDSN has a web-based portal used by each contracted provider agency to submit reports. A full-time Incident Management Coordinator reviews each report upon submission to ensure all necessary details are covered.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. Use of Restraints. *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

○ **The state does not permit or prohibits the use of restraints**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

◉ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

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

In accordance with DDSN policy, restraints may be employed only for the purpose of protecting the person or others from harm and only when it is determined to be the least restrictive alternative possible to meet the person's needs. The following types of restraints may be used:
(1.) Planned restraint (mechanical or manual) when approved by the person his/her legal guardian, the program director/supervisor, an approved provder of behavior support services, the Human Rights Committee (HRC) of the Executive Director.
(2.) Mechanical restraints to allow healing of injury produced by an inappropriate behavior when approved by the person or his/her legal guardian, the program director/supervisor, an approved provider of behavior support services, the HRC, and the Executive Director.
(3.) Psychotropic medication when approved by the person or legal guardian, the program director/supervisor, an approved provider of behavior support services, the HRC, and the Executive Director.

The use of the following are prohibited by DDSN policy:
(1.) Procedures, devices, or medication used for disciplinary purposes, for the convenience of the staff or as a substitute for necessary supports for the person;
(2.) Seclusion (defined as the placement of an individual alone in a locked room);
(3.) Enclosed cribs;
(4.) Programs that result in a nutritionally inadequate diet or the denial of a regularly scheduled meal;
(5.) Having a service recipient discipline other people with disabilities;
(6.) Prone (i.e., face down on the floor with arms folded under the chest) basket-hold restraint;
(7.) Timeout rooms; and,
(8.) Aversive consequence (defined as the application of startling, unpleasant, or painful consequences) unless specifically approved by the State Director of DDSN or his/her designee.

The unauthorized or inappropriate use of restraints would be considered abuse by the State; therefore, the same methods used to detect abuse (e.g., staff supervision, identification of situations that may increase risk, etc.) are employed to detect inappropriate use of restraints/seclusion.

The State's policy requires that only curricula or systems for teaching and certifying staff to prevent and respond to disruptive and crisis situations that are validated and competency-based be employed. Any system employed must emphasize prevention and de-escalation techniques and be designed to utilize physical confrontation only as a last resort. Each system dictates its own specific certification and re-certification procedures. Examples of systems approved by the State are MANDT, Crisis Prevention Institute (CPI), and Professional Crisis Management (PCM).

Any individual program that involves restrictive procedures may only be implemented when less restrictive procedures are proven ineffective. Restrictions may only be implemented with the informed consent of the individual/representative and with the approval of the Human Rights Committee. Restrictions must be monitored by staff, and the behavior supports provider, and the HRC. Additionally, when planned restraints are employed, State policy requires that restraints may not be applied for more than one continuous hour and release must occur when the person is calm. Mechanical restraints must be applied under continuous observations.

DDSN utilizes a QIO to conduct contract compliance reviews which include direct observation of service provision and record reviews. The QIO reviews include, but are not limited to, determining if staff are appropriately trained, that risk management and quality assurance systems are implemented consistent with policy, and that abuse and critical incidents are reported and responded to in accordance with policy. Additionally, the QIO determines if individuals are provided the degree and type of supervision needed but not inappropriately restricted. QIO follow-up reviews are conducted approximately 6 months after initial reviews. Information collected by the QIO is shared with DHHS.

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

DDSN is responsible for oversight of the use of restraints. DDSN policies dictate the responsibilities of service providers and the HRC regarding monitoring programs that include restraint. DDSN monitors compliance with policies through its contract compliance reviews conducted by the QIO and through its licensing reviews.

Contract compliance review and licensing review reports are provided to SCDHHS per the requirements of the MOA. Traditional survey methods including record reviews, staff interviews, and observation are implemented to detect unauthorized use, over use, or inappropriate/ineffective use of restraint procedures. Deficiencies noted must be addressed in a written plan of correction that provides individual and systemic remediation. DDSN provides technical assistance as needed based on findings. Follow-up reviews are conducted, as needed.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

○ **The state does not permit or prohibits the use of restrictive interventions**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

◉ **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

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

DDSN policy allows the use of:
(1.) Restrictive procedures (procedures that limit freedom or cause loss of personal property or rights excluding restraint) when approved by the person or his/her legal guardian, the program director/supervisor, an approved behavior support provider, and the Human Rights Committee (HRC).
(2.) Adverse consequences which are defined as startling, unpleasant or painful consequences, consequences that have a potentially noxious effect, when approved by the person or his/her legal guardian, the physician, an approved provider of behavior support services, HRC, the Executive Director, and the State Director of DDSN. Such procedures may only be employed to protect the person or others from harm and only when it is determined to be the least restrictive alternative possible to meet the needs of the person.

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:

DDSN is responsible for oversight of the use of the restrictive procedures. DDSN policies dictate the responsibilities of service providers and the HRC regarding monitoring programs that include restrictive procedures. DDSN monitors compliance with policies through its contract compliance reviews conducted by the QIO and through its licensing reviews. When adverse consequences are approved, in addition to monitoring through contractual compliance and licensing reviews, the procedures are monitored by a DDSN state office staff person.

DDSN Standards and Directives referenced include the following:
Behavior Support Plans 600-05-DD
Human Rights Committee 535-02-DD

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

◉ **The state does not permit or prohibits the use of seclusion**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

Seclusion (defined as the placement of an individual alone in a locked room), enclosed cribs, and timeout rooms are prohibited by State DDSN policy.

DDSN utilizes a QIO to conduct contract compliance reviews every 12-18 months which include direct observation of service provision and record reviews. The QIO reviews include, but are not limited to, determining if staff are appropriately trained, that risk management and quality assurance systems are implemented consistent with policy, and that abuse and critical incidents are reported and responded to in accordance with policy.

○ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

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

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

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed

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

a. Applicability. Select one:

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

◉ **Yes. This Appendix applies** *(complete the remaining items)*

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.

DDSN's contracted QIO conducts quality assurance reviews every 12 to 18 months, depending on the past performance of the particular provider. Licensing inspections, which include a detailed review of the Medication Administration Records, Medication Error Reports and safe medication handling practices, are also coordinated by the QIO and take place on a rolling schedule for each provider location. All Day service locations are inspected annually. Residential locations serving adults and children are inspected on a annual basis. As part of this process, DDSN Directive 100-29-DD: "Medication Error Reporting" requires the provider to maintain a medication error rate in addition to the individual error reports. This medication error rate is reviewed during the licensing inspection and during the provider's quality assurance review, which are scheduled at different times. In addition, the provider must track, trend and analyze medication errors found at any location throughout the agency and document findings in the quarterly risk management meetings. Any citations resulting from quality assurance or licensing reviews will require a plan of correction and a follow-up review by the QIO to ensure appropriate remediation. For any medication errors having an adverse reaction resulting in medical intervention, the provider must complete a Critical Incident Report, as outlined in DDSN Directive 100-09-DD, within 24 hours of the incident. A management review of the incident must be submitted within 10 business days and DDSN may determine if any additional actions are needed.

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.

DDSN has established a procedural directive, "Medication Error Reporting," to standardize the definition and reporting system for medication errors/events in order to improve the health and safety of DDSN consumers. DDSN recognizes that medication errors represent one of the largest categories of treatment-caused risks to consumers. As a result, every agency that provides services and supports to people must have a medication error/event reporting, analyzing, and follow-up capability, as part of their overall risk management program. Safe medication requires training, experience, and concentration on the part of the person dispensing the medication. The provider's system of tracking, trending, and analyzing their Medication Error data is reviewed by the QIO.

The National Coordinating Council for Medication Error Reporting and Prevention (NCC MERP) has urged agencies, institutions, and researchers to utilize this standard definition of medication errors. DDSN has adopted this definition. (For more information on NCC MERP, please see ww.nccmerp.org.) "A medication error is any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient, or consumer. Such events may be related to professional practice, health care products, procedures, and systems, including prescribing; order communication; product labeling, packaging, and nomenclature; compounding; dispensing; administration; education; monitoring; and use." DDSN has followed the general guidelines of the NCC MERP "Taxonomy of Medication Errors" in developing a Medication Error/Event Report Form. DDSN Service Providers are required to develop their own data collection system to track, monitor and analyze medication errors/events. At the provider level, reactive and proactive analysis of trends should be coupled with appropriate corrective actions. These actions may include, but are not limited to, additional training (including Medication Technician Training), changes in procedure, securing additional technical assistance from a consulting pharmacist, and improving levels of supervision. DDSN is the state agency responsible for follow-up and monitoring and, as such, may request all data related to medication error/event reporting at any time or during any of the Service Provider's reviews.

Appendix G: Participant Safeguards

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

c. Medication Administration by Waiver Providers

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

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

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).

DDSN was granted the statutory authority for selected unlicensed persons to administer medications to DDSN service recipients in community settings. DDSN policy requires that staff receive training on medication assistance/administration prior to service.

DDSN sets forth the minimum requirements for medication administration or assistance, which includes: checking physicians orders, knowing common medications prescribed for the individuals supported and indentifying their interactions/side effects, administering medications/treatments accurately and in accordance with agency policy, and recording medication administration on the appropriate forms. Staff must demonstrate knowledge/understanding of these minimum competencies on an annual basis.

DDSN requires that errors in administration of medications to service recipients must be reported, recorded, and that trends be analyzed. Additionally, both reactive and proactive follow-up activities following reports must be completed and documented.

DDSN monitors the administration of medication through annual licensing/certification reviews and monitors compliance with medication error reporting through the agencys contract compliance reviews.

Additionally, DDSN recommends that all providers utilize an established Medication Technician Certification Program, which includes sixteen hours of classroom instruction and practicum experience taught by a Registered Nurse and supervised medication passes.

The Standards or Directives referenced include:
Employee Orientation, Pre-Service and Annual Training (567-01-DD)
Residential Certification Standards
Day Facilities Licensing Standards
Medication Error/ Vent Reporting (100-29-DD)
Medication Technician Certification (603-13-DD)

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:

Significant Medication Errors are reported to SCDDSN as a Critical Incident. All Medication Error/Event reports are subject to periodic review by SCDDSN or its QIO.

SCDDSN has adopted the NCC MERP definition of Medication Errors: A medication error is any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient or consumer. SC DDSN has followed the general guidelines of the NCC MERP Taxonomy of Medication Errors in developing a Medication Error/Event Report Form. SCDDSN Service Providers are required to develop their own data collection system to track, monitor and analyze medication errors/events. At the provider level reactive and proactive analysis of trends should be coupled with appropriate corrective actions. These actions may include, but are not limited to, additional training (including medication technician certification), changes in procedure, securing additional technical assistance from a consulting pharmacist, and improving levels of supervision. SCDDSN may request all data related to medication error/event reporting at any time or during any of the Service Providers annual reviews.

Types of Medication Errors/Events
According to the above definition, there are some kinds of medication errors that are outside the control of SCDDSN and its network of service providers (e.g., naming; compounding; packaging etc.). If provider agency staff discovers errors of this type, the pharmacist should be notified immediately in order for corrective action to occur. The types of medication errors/events that are within the direct control of SCDDNS and its network of service providers, and therefore of most interest, can be divided into three categories: 1) bona fide or true medication errors; 2) transcription and documentation errors; and 3) red flag events.

1) MEDICATION ERRORS
Wrong person given a medication
Wrong medication given
Wrong dosage given
Wrong route of administration
Wrong time
Medication not given by staff (i.e., omission)
Medication given without a prescribers order

2) TRANSCRIPTION & DOCUMENTATION ERRORS
Transcription error (i.e., from prescribers order to label, or from label to MAR)
Medication not documented (i.e., not signed off)

3) RED FLAG EVENTS
Person refuses medication (this event should prompt the organization to make every effort to determine why the person refused the medication. Specific action taken should be documented. Each organization must develop a reporting system for these events).

Reporting Procedure
The first person finding the medication error is responsible to report the error or event to supervisory/administrative staff, such as the employees supervisor, program director, nurse in charge or Executive Director/Facility Administrator. A medication error resulting in serious adverse reactions must be considered a critical incident and reported according to policy. The person finding the error or identifying the event completes the Medication Error/Event Report form and submits it to the supervisor/administrator. The Provider Administration will assure this data is available to the quality assurance and risk management staff/team for analysis, trend identification, and follow-up activity as needed. In addition, the Medication Error/ Event records are reviewed during the providers annual licensing review. The QIO also reviews Medication Error/Event data and the providers analysis and risk management activities during their scheduled reviews.

Each provider must adopt a method for documenting follow-up activities such as utilizing memoranda or the minutes of risk management/quality assurance meetings. This information must be included as part of the data collection system related to medication error/event reporting.

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.

DDSN is responsible for monitoring the performance of Waiver providers in the administration of medication. DDSN requires all providers to follow the policy/procedures outlined in the previous responses. DDSN may request all data related to medication error/event reporting at any time or during any of the Service Provider's reviews. In addition, DHHS may review the Provider documentation at any time.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: Health and Welfare
The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
CS Waiver Providers complete the internal review for incidents of abuse, neglect, exploitation & unexplained death within required timeframe. N= Number of CS Waiver Providers who completed the internal review for incidents of ANE & UD within the required timeframe: D= total number of ANE & UD incidents reported for CS participants.

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

Responsible Party for data	**Frequency of data collection/generation**	**Sampling Approach** *(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**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**

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

Performance Measure:
CS waiver participants and/or legal guardian receive information yearly about how to report abuse, neglect and exploitation. N= Number of CS waiver participants and/or legal guardian who receive information yearly about how to report AN&E; D= total number of CS waiver participant records reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
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: DDSN QIO Contractor	☐ **Annually**	☒ **Stratified** Describe Group: Stratified Sampling Approach is based on the size of the provider.
	☒ **Continuously and Ongoing**	☐ **Other** Specify:

	☒ **Other** Specify: QIO Reviews are conducted every 12-18 months depending on past performance of the provider organization.	

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 substantiated incidents of abuse, neglect, exploitation and unexplained deaths for CS waiver participants. N= Number of substantiated incidents of ANE & UD for CS waiver participants; D= total number of reported incidents of ANE & UD for CS waiver participants.

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**

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

Performance Measure:
Providers report incidents of abuse, neglect, exploitation and unexplained deaths within required timeframe. N= Number of CS waiver participant incidents of ANE & UD that are reported in the required timeframe; D= total number of ANE & UD for CS waiver participants.

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
Critical Incidents for CS waiver participants are reported on the incident

management system. N= Number of CS waiver participants with critical incidents reported on the incident management system; D= total number of critical incidents for all waiver participants using the incident management system.

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
CS Waiver participants with reported incidents of restrictive interventions that are inconsistent with policy. N= Number of CS waiver participants with reported incidents of restrictive interventions that are inconsistent with policy; D= total number CS waiver participant records reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
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**	☒ **Stratified** Describe Group: Stratified Sampling Approach is based on the size of the provider.
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
CS Waiver participants report access to healthcare services as listed on the person centered plan/assessment per waiver policy. N= Number of CS Waiver participants who report access to healthcare services; D= total number of CS waiver files reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
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**	☒ **Stratified** Describe Group: Stratified Sampling Approach is based on the size of the provider.
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
CS Day Service Providers report medication errors/incidents in accordance to policy.
N= Number of CS Day Service Providers who report medication errors/incidents in

accordance to policy; D= total number of CS Day Service Providers reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
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: DDSN QIO Contractor	☐ **Annually**	☒ **Stratified** Describe Group: Stratified Sampling Approach is based on the size of the provider.
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: DDSN QIO Contractor	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States 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 contracts with an independednt QIO to conduct provider compliance reviews. Administrative Key Indicators are included with each compliance review. The Administrative Review determinates if the organization has systems in place that identify whether employees are reporting according to State Law and DDSN policy, and responding appropriately. There are separate indicators to address abuse, neglect, exploitation (ANE), reporting procedures, risk management, and prevention.

DDSN collects, responds and reports data related to other critical incidents that do not rise to the level of ANE. DDSN employs a full-time Incident Management Coordinator who tracks reports throughout the system to ensure compliance with State Law and DDSN policy. This review covers reporting within the appropriate time frames, completion of internal reviews, and a review of the provider's management action taken to remediate identified issues such as staff training, staff suspension or termination, updates to risk management and quality assurance procedures and policies and other measures to provide safeguards for the consumers. This data is also reviewed by the SCDDSN Director of Quality Management for trending analysis at both the provider and statewide levels along with corresponding QIO and Licensing data.

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**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: DDSN QIO Contractor	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix H: Quality Improvement Strategy (1 of 3)

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

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

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

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

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the

waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

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

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

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

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

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The objective of DDSN's Quality Management Systems is to identify positive and negative trends allowing for necessary adjustments to enhance the overall performance of the system.

DDSN's system improvement activities are designed to ensure that they address all six (6) CMS assurances based on performance measures. Statewide problems can be addressed through any of the following: 1) revisions to the training program; 2) revisions of policy and/or procedures; or 3) modifications to improve the data reporting system.

Timely discovery and remediation of aggregated data allows the state to take the necessary action to improve the systems performance, thereby learning how to improve meaningful outcomes for waiver participants. DDSN contracts with an independent QIO to assess service providers by making on-site visits. Records are reviewed, consumers and staff are interviewed, and observations made to evaluate that services are implemented as planned, and that needs are identified in the Plan of care. In addition, the service providers are reviewed to ensure compliance with DDSN standards, contracts, policies and procedures.

DDSN monitors the QIO reports approximately 30 days after the review date to ensure overall compliance with QA measures and to determine appropriate remediation. For each finding, the provider must submit a plan of correction (POC) within 30 days to the QIO and the QIO conducts a follow-up review approximately 6 months later to ensure successful implementation of the POC. The POC will address remediation at the individual level. DDSN District Office staff are also available to provide training and technical assistance as needed.

DDSN also monitors the QIO reports of findings to identify larger system-wide issues that require training and/or technical assistance. This information is addressed through quarterly counterpart meetings with DDSN District Office staff personnel. Additionally, DDSN will communicate information quarterly through on-site meetings, webinars, email, and/or web-site postings. DHHS will have access to this information.

DDSN is able to stratify information related to each approved waiver program and is also able to stratify by provider and waiver type. DDSN's Quality Management System has formal processes and activities in place for trending, prioritizing, and implementing system improvements. DDSN is continuously reviewing and updating its Quality Management System processes to ensure it is responsive to the quality assurances.

DDSN provides DHHS with the results of all quality assurance review activities throughout the year. This includes, but is not limited to, critical incident data, results of all QIO provider reviews, and licensing data.

DDSN performs a stratified sampling approach when the when the sampling approach is less than 100% review. The number of files reviewed is based on the size of the provider. DDSN uses the following table to determine the sampling approach:

DDSN Stratified Sampling Approach:

Provider sample size	Sample Size (#Files)	Criteria for determining size of provider
Very Large Provider	7% Up to 45	700+
Large Provider	8%	150-699
Medium Provider	12	50-149
Small Provider	7	0-49

The State maintains a MOA and a waiver service contract to outline the responsibilities for the operating agency and the administrating agency as they participate in joint quality improvement and trend analysis efforts.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Quality Improvement Committee**	☒ **Annually**
☒ **Other** Specify: DDSN QIO Contractor	☒ **Other** Specify: DDSN QIO Reviews are conducted every 12-18 monoths per past provider performance.

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

DDSN has a comprehensive incident management system which allows the State Office and individual provider agencies to track, trend and analyze reporting information. This information may include: the number and proportion of reports of abuse, neglect and exploitation; the number and proportion of reported incidents of substantiated abuse, neglect and exploitation; and the number and proportion and critical incidents (including mortality, injuries and client-to-client altercations).

The State schedules quarterly meetings to review policy and any pertinent waiver issues. Quality Assurance/Quality Improvement is generally a standing agenda item.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

DHHS and DDSN meet periodically to discuss the effectiveness of Quality Improvement initiatives implemented by both state agencies. Changes recommended to the overall quality system are brought to the DHHS/DDSN Policy Committee for review.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months *(Select one):*

- ◉ **No**
- ○ **Yes** *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

- ○ **HCBS CAHPS Survey :**
- ○ **NCI Survey :**
- ○ **NCI AD Survey :**
- ○ **Other** *(Please provide a description of the survey tool used):*

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. *Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).*

DHHS and DDSN both use CMS-approved Quality Improvement Organizations for different aspects of quality management reviews, all of which contribute to financial integrity and accountability. The DDSN QIO provider reviews consist of three components: staffing reviews, administrative reviews and participant reviews. The staffing reviews sample staff members at different levels of the organization to ensure they meet all initial training and certification requirements, tuberculin skin test requirements, ongoing training requirements and all other specified 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 waiver services have been met.

DDSN's Internal Audit Division conducts periodic reviews of the billing systems and contracted providers to insure billings are appropriate. These audits are conducted using a selected sample. Findings are shared with DHHS. 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 within 30 days of completion. 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 within 30 days of completion. DHHS will review DDSN Internal Audit Division annual reports, special request audits, and fraudulent case investigations and request remedial action(s) as determined necessary.

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 audits any 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 DHHS Division of Audits reviews DHHS contracts with external entities in order to ensure that contract terms are met and only allowable costs are charged.

Each DSN Board is required to perform a yearly audit of their financial position. These yearly audits are performed by independent CPA firms to determine if provider agencies are upholding generally accepted accounting practices and are maintaining a sound financial position.

Reviews are onsite, both by DDSN's QIO and DDSN's Internal Audit. Plan of Corrections are submitted and follow-up reviews are conducted. Exit conferences are held and final written reports are submitted on all reviews. Through the DDSN QIO process, the preliminary results of the review are discussed on-site with the provider at the conclusion of the review; a written resort of findings is issued to the provider and a written plan of correction with response for each finding is required. Follow-up reviews are conducted to determine if the plan of correction was implemented and if identified deficiencies have been corrected both individually and systemically. DDSN's Internal Audit also conducts on-site reviews and follows the same basic format. DHHS's PI reviews documentation of DDSN providers that service note level which support activities billed and issues recoupments of all discrepancies. DDSN does not conduct program integrity reviews.

Audit metrics are used to prioritize reviews and in order to ensure that provider organizations are reviewed on a periodic bases. DDSN requires external auditors to conduct reviews of census data that are used for billing every year. DDSN's Internal Audit conducts special request audits when requested.

DDSN requires Boards to engage independent CPA firms annually to perform yearly financial audits. CPA firms perform on an annual basis financial audits of waiver services. Each DSN Board must submit an annual audit conducted by an independent CPA firm. The audit must determine if GAAPs are upheld, the agency's financial position is sound and all funds received are being properly expended. The results of each provider's audit is submitted to DDSN IT for review and follow-up.

Program Integrity (PI) makes scheduled visits with DSN Boards, other qualified providers or DDSN, based on complaints, referrals and findings to ensure records and meeting space is available. PI also makes unannounced visits for other reasons. Those visit schedules are not shared and their findings are independent. PI conducts both desk and field reviews, on-site inspections, and/or investigations of providers to determine whether the provider is complying with all applicable laws, rules, regulations, and agreements. During such reviews, PI staff will request medical records and related documents as well as conduct interviews and perform investigations. PI staff will thoroughly review the records to determine whether the documentation accurately represents paid claims and rendered services, and whether the provider is in compliance with its obligations to the state Medicaid program. The documentation must sufficiently disclose the extent of services delivered, medical necessity, appropriateness of treatment, quality of care, and the documentation adheres to all applicable policy requirements.

The South Carolina State Auditor's Office is responsible for performing the Single State Act audit.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability Assurance:
The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

i. Sub-Assurances:

a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered. *(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
Proportion of paid claims for CS waiver services identified on an approved service plan.
N= Number of paid claims for CS waiver services identified on an approved service plan; D= total number of CS waiver participant paid claims reviewed.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
DHHS Desk/Focus 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***	☐ ***Stratified*** *Describe Group:*
	☒ ***Continuously and Ongoing***	☒ ***Other*** *Specify:* *Sampling determined by evidence warranting a special review.*
	☐ ***Other*** *Specify:*	

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
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***	☒ ***Stratified*** *Describe Group:*

DDSN QIO Contractor		*Stratified Sampling Approach is based on the size of the provider.*
	☒ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☒ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☒ ***Other*** *Specify:* *DDSN QIO Contractor*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

Performance Measure:
Paid claims for CS waiver participants are paid in accordance with the approved waiver policy. N= Number of paid claims for CS waiver participants that are coded and paid in accordance with the approved waiver policy; D= total number of CS claims reviewed.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Paid Claims in Medicaid Management Information System

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

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
DHHS Focus/Desk 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***	☐ ***Stratified*** *Describe Group:*
	☒ ***Continuously and Ongoing***	☒ ***Other*** *Specify:* *Sampling determined by evidence warranting a special review.*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

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

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

Performance Measure:
CS waiver participants whose annual waiver expenditures were within the CS Cost Cap according to waiver policy. N= Number of CS waiver participants whose annual waiver expenditures were within the CS Cost Cap according to waiver policy; D= total number of CS waiver participants reviewed.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
DHHS Focus 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***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

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

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
CS waiver service rates remain consistent with approved methodology. N= Number of CS waiver service rates that remain consistent with approved methodology; D= total number of CS waiver service rates.

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

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☒ ***100% Review***

☐ ***Operating Agency***	☐ ***Monthly***	☐ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☐ ***Representative Sample*** *Confidence Interval =*
☐ ***Other*** *Specify:*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

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

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

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.*

DDSNs Internal Audit division conducts periodic reviews of billing systems and contracted providers to ensure 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

i. *Describe the States 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 reviews and amends its' financial policies and procedures upon review and approval by DHHS. DHHS Financial policy requires DDSN to void/replace incorrect claims using the web-based system whenever possible. Some corrections require submission of manual adjustments. QA reviews that identify inappropriate payments due to invalid Level of Care Determinations or incomplete Plan of Service Documents, for example, generate an automatic referral to DHHS-Program Integrity for an independent record review and, if warranted, recoupment of Federal Financial Participation (FFP). DHHS requires DDSN to include recoupable review findings in field staff training.

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:* *As warranted*

c. Timelines

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

◉ ***No***

○ ***Yes***

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

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. *In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).*

The SCDHHS, Department of Reimbursement Methodology and Policy, in collaboration with the SCDHHS Division of Community Options, and the SCDDSN, is responsible for the development of waiver service payment rates. The SCDHHS allows the public to offer comments on waiver rates changes and rate setting methodology either through Medical Care Advisory Committee meetings, public hearings, or through meetings with association representatives. The SCDHHS receives contractually required annual cost report submissions from SCDDSN for the Community Supports waiver services provided by the Disabilities and Special Needs Boards (38) across the state. As of October 1, 2012, the date of implementation of our prospective payment system, these reports are used to substantiate Certified Public Expenditures only.

The costs of the Boards are initially accumulated and compiled into four regional consolidated reports. The costs are separated by medical service/waiver. The SCDDSN also contracts with SCDHHS for the services of ICF/IID (Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)), TCM (Targeted Case Management), Early Intervention, Rehabilitative Behavioral Health services, as well as two other HCBS waivers. As a comprehensive health care provider, the SCDDSN uses the CMS form 2552 to distribute or step down the cost of general service and supporting cost centers to the benefitting services and waivers. Upon completion of the 2552 format, the SCDDSN then prepares a Community Supports waiver specific cost report which further delineates cost among the specific services provided within the waiver. Utilization statistics (units of service) for the specific waiver services are accumulated by SCDDSN for the total population of users of the services and reported in the cost report.

Upon receipt of the annual reports, staff of the Department of Reimbursement Methodology and Policy review the reports for accuracy, reasonableness, and compliance with Medicare cost definitions. Samples of cost and service data from individual Boards (chosen from each regional report) are reviewed for compliance and then traced into the applicable supporting worksheets within the waiver cost report. Upon the completion and determination of allowable costs, the average cost per unit for each waiver service is calculated by dividing the total allowable cost per service by the total units of service for that service (i.e. for the total population of service recipients). The SCDHHS uses Medicare cost principles as reflected in the CMS Provider Reimbursement Manual (HIM-15) as our guidance for establishing allowable cost definitions for non-institutional cost reports required by SCDHHS.

For the waiver services provided by DDSN's Boards under contract, the 2010 cost report was used to establish prospective rates as of October 1, 2012. The average SFY 2010 cost per unit for each contracted service becomes the basis for rates effective with October 1, 2012 dates of service. To approximate allowable Medicaid costs, the 2010 rates were trended by a rate of 3.76%. The trend factor was determined by using the Medicare Economic Index (MEI) for Calendar Year 2010 (1.2%) and multiplying the index by the number of years between the midpoint of the cost reporting year (January 2010) and the midpoint of the rate year (February 14, 2013). Note: Cost reporting year = 07/01/09-06/30/10 and Rate year = 10/01/12-06/30/13.

To provide some background on the current status of cost reports for this waiver (and the two other waiver administered by the contractor SCDDSN), SCDHHS has been working with SCDDSN, with technical assistance and oversight from CMS, in finalizing the proper treatment of SCDDSN Central Office administrative costs from the SFY 2012 cost report submission among state plan and waiver services. The SCDHHS completed its review of the SFY 2012 SCDDSN central office administrative cost allocation methodology to ensure compliance with the cost allocation methodology previously agreed to between CMS and SCDHHS and submitted the results of our review to CMS for comment and official approval.

This process is the initial step of the compliance measures required by a CMS review that included the instruction to remove non-service related SCDDSN Central Office administrative costs from reimbursable service costs for periods January 1, 2011 and forward. Once the initial step of identifying and properly reclassifying the SFY 2012 SCDDSN Central Office administrative costs has been completed, the following processes must be completed to ensure compliance with the CMS review:
1) Waiver service costs previously submitted on the SFY 2011 cost report must be revised to reflect the reduction of SCDDSN Central Office administrative costs for the period January 1, 2011 through June 30, 2011.
2) Waiver cost reports for the SFYs 2013 forward can be filed by SCDDSN using the same cost finding and classification methodology as related to the SCDDSN Central Office administrative costs as was used in the determination of allowable waiver costs for SFY 2012.
3) Prospective waiver rates for the periods October 1, 2012 and currently in effect (based on SFY 2010 cost reports) must be adjusted for a factor which approximates the value of SCDDSN Central Office administrative costs which were included in the original prospective rate determination.

4) Effect all rate revisions in MMIS and outstanding cost settlements (and rate revision settlements) to SCDDSN for the affected cost reporting years and rate periods.
5) An analysis of the current prospective rates, as revised for the deletion of the Central Office Administrative costs, to access the need for a rebasing of rates to align rates to projected current costs.

The processes and procedures noted above are extensive and encompass effectively all of the Medicaid services rendered by SCDDSN. As part of this effort, the SCDHHS ensured that indirect costs associated with room and board have been properly determined and removed from allowable Medicaid reimbursable waiver costs. These efforts have required the participation of SCDHHS, SCDDSN and CMS staff.

The SCDDSN SFY 2012 cost report review was completed and submitted to CMS for approval and concurrence that the SCDDSN Central Office administrative cost was allocated in accordance with the previously-approved CMS cost allocation methodology. Only one change was requested by CMS related to the allocation statistics used to allocate information technology costs (CMS requires the use of accumulated costs for this cost center in lieu of time usage between administrative and service functions). SCDHHS has made the appropriate adjustments and has ensured the proper treatment of SCDDSN CO costs when it determines allowable Medicaid reimbursable costs for its SFY 2012 CPE analysis.

The SCDHHS is employing the services of Myers and Stauffer to complete the outstanding SCDDSN cost reports. Myers and Stauffer and SCDDSN are completing the SFY 2016 cost reports for submission in the early spring of 2019. The SCDHHS will use the SFY 2016 cost reports to rebase rates for both state plan and waiver services after ensuring that only allowable Medicaid reimbursable costs are included. Standard desk review procedures as previously described will be applied to the SFY 2016 cost reports to assure adherence with SC Medicaid reimbursement policies relating to accuracy, reasonableness, and compliance with Medicare cost definitions. After review and subsequent determination of average SFY 2016 per unit (per service) costs, a trend factor will be applied to approximate allowable Medicaid costs at the point of implementation. The trended rates will be further tested and evaluated against "constructed market rates" developed by an outside consultant to ensure compliance with economic and efficient requirements.

Please note that as we move forward beyond these compliance efforts and complete future annual cost report reviews, necessitated due to Certified Public expenditure funding, prospective rates will be reviewed annually to ensure efficient and economic rates sufficient to provide quality care.

The rate narrative above applies to the following services directly administered by the SCDDSN:
Respite/Institutional/ICF/MR
Respite/In-Home/Hourly
Day Activity
Career Preparation
Community Services
Employment Services Individual
Employment Services Group
Support Center Services
In-Home Support
Private Vehicle Modifications
Private Vehicle Assessment/Consult
Supplies/Assistive Technology/Appliances
Assistive Technology and Appliances Assessment/Consult
Environmental Modifications
Behavior Support

Waiver case management rates (travel/without travel) were constructed based on the governmental provider's salary and fringe data, estimates of associated direct operational costs and application of an indirect rate for support costs. Productivity standards, again supplied by the governmental provider, applied against annual hours per FTE were used to develop the hourly (and billable 15 minute) rate.

Personal Care (I and II), Adult Day Health Care, Adult Day Health Nursing, and Adult Day Health Transportation services provided by a CLTC provider (i.e. private agency) are paid the rate as established for the Community Choices

waiver.

Incontinence supplies for the seven waivers administered by SCDHHS are reimbursed from a fee schedule developed based on market analysis and last updated on July 11, 2011.

PERS Installation (and Monthly fee) rates are based on market private pay rates. The original rates have been reduced as technological improvements reduced costs. Installation has always been tied to the cost of one month of service.

Rates for Adult Dental, Adult Vision, Audiology, and Nursing are taken directly from the State Plan service rates for the 21 and under population.

Prospective payment system rates for the ID/RD waiver are included as appendices in the contracts signed by SCDDSN and other CLTC providers rendering services. SCDDSN includes the schedule of services in their provider service portal.
Participants are notified of rate changes by their case managers as appropriate. Participants registering to be included on
the SCDHHS provider distribution list receive alerts and bulletins via email.

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 SCDHHS or they may voluntarily contract with SCDDSN to submit their claims. Providers billing SCDHHS directly may bill either by use of a CMS 1500 claim form or by the SCDHHS electronic billing system/web-tool.

Providers/others may obtain more information at: https://medicaidelearning.remote-learner.net/mod/page/view.php?id=1084

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one):*

○ ***No. state or local government agencies do not certify expenditures for waiver services.***

◉ ***Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.***

Select at least one:

☒ ***Certified Public Expenditures (CPE) of State Public Agencies.***

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).(Indicate source of revenue for CPEs in Item I-4-a.)

(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 (i.e.
ICF/IID) and all waiver service providers.
(c) SCDDSN receives annual state appropriations for these services. The contract between SCDHHS and SCDDSN applicable to these services includes 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 45 CFR 95.13, 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."

SCDHHS considers Medicaid revenue to consist of the actual Medicaid payments made by the agency plus any third-party recoveries plus any co-pays (if applicable). This Medicaid revenue is then compared to total allowable Medicaid reimbursable costs to ensure that total Medicaid allowable reimbursable costs equal or exceed Medicaid revenue for CPE compliance reviews.

☐ ***Certified Public Expenditures (CPE) of Local Government Agencies.***

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. *Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:*

Claims for waiver services are submitted to MMIS through either the use of a CMS 1500 claim form or through the SCDHHS electronic billing system. Providers of most waiver services are given a service authorization which reflects the service identified on the service plan. This authorization form is produced by the WCM/EI provider and contains the frequency, date and type of service authorized along with a unique authorization number. 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 a special indicator in MMIS that indicates the participant is enrolled in the waiver program.

This recipient special program (RSP) indicator and Medicaid eligibility is required for payment of all waiver claims. Other waiver services, such as extra prescription drugs, are authorized simply by the presentation of the waiver participant's Medicaid card. When the Medicaid number is entered into the proper electronic system, it will identify the waiver benefit available to the individual. This is all linked to the RSP in MMIS identifying an individual as a waiver participant.

The South Carolina Department of Health and Human Services ensures the integrity of the Medicaid Program and seeks to identify and reduce waste, fraud, and abuse in the use of Medicaid funds through the activities carried out by the Division of Program Integrity and the Division of Audits. The purposes of program oversight are to safeguard against unnecessary, inappropriate, and/or fraudulent use of Medicaid services, identify excessive or inaccurate payments to providers, and ensure compliance with then applicable Medicaid laws, regulations, and policies.

POST PAYMENT REVIEW
The Division of Program Integrity conducts post-payment reviews of all health care provider types. Program Integrity uses several methods to identify areas for review:
• A toll-free Fraud and Abuse Hotline and the Fraud and Abuse email account for complaints of provider and beneficiary fraud and abuse.
• The automated Surveillance and Utilization Review System (SURS) which creates provider profiles and exception reports that identify excessive or aberrant billing practices.
• Referrals from other sources

SECTION 1 GENERAL INFORMATION AND ADMINISTRATION
The Division conducts payment reviews, analysis of provider payments, and review of provider Records to determine the following:
• Medical reasonableness and necessity of the service provided
• Indications of fraud or abuse in billing the Medicaid program
• Compliance with Medicaid program coverage and payment policies
• Compliance with state and federal Medicaid laws and regulations
• Compliance with accepted medical coding conventions, procedures, and standards
• Whether the amount, scope, and duration of the services billed to Medicaid are fully documented in the provider's records

The Division of Program Integrity ("Program Integrity") conducts both announced and unannounced desk and field reviews, on-site inspections, and/or investigations of providers to determine whether the provider is complying with all applicable laws, rules, regulations, and agreements. During such reviews, Program Integrity staff will request medical records and related documents as well as conduct interviews and perform investigations. Program Integrity staff will thoroughly review the records to determine whether the documentation accurately represents paid claims and rendered services, and whether the provider is in compliance with its obligations to the state Medicaid program. The documentation must sufficiently disclose the extent of services delivered, medical necessity, appropriateness of treatment, quality of care, and the documentation adheres to all applicable policy requirements. As part of the QA review process, the DHHS Community Options staff review case notes to ensure language exists confirming delivery of services.

SANCTIONS
Sanctions including but not limited to suspension, termination, or exclusion from the Medicaid program may result upon the failure of the provider to:
• Allow immediate access to records
• Repay in full the identified overpayment
• Make arrangements for the repayment of identified overpayments
• Abide by repayment terms
• Make payments which are sufficient to remedy the established overpayment

Failure to provide requested records may result in one or more of the following actions by SCDHHS:
• Immediate suspension of future payments
• Denial of future claims
• Recoupment of previously paid claims

In order to ensure that claims presented by a provider for payment meet the requirements of federal and state laws and regulations, a provider may be required to undergo prepayment claims review. Grounds for being placed on prepayment claims review shall include, but shall not be limited to identification of aberrant billing practices as a result of reviews, investigations, or data analysis performed by Program Integrity/SUR, or other grounds as determined by Program Integrity/SUR. A provider is removed from prepayment review only when determined appropriate by Program Integrity/SUR. Once removed from prepayment review, a follow-up assessment of the provider's subsequent practice patterns may be performed to monitor and ensure continued appropriate use of resources. Noncompliant providers are subject to administrative sanctions.

RECOVERY AUDIT CONTRACTOR
The South Carolina Department of Health and Human Services, Division of Program Integrity, contracts with a Recovery Audit Contractor to assist in identifying and collecting improper payments paid to providers as a result of billing errors as referenced in 42 CFR 476.71.

The SCDDSN Internal Audit Division periodically conducts audits of SCDDSN'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 §92.42.*

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS *(select one):*

◉ ***Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).***

○ ***Payments for some, but not all, waiver services are made through an approved MMIS.***

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

○ ***Payments for waiver services are not made through an approved MMIS.***

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

○ ***Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.***

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. *In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):*

- [x] ***The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.***
- [ ] ***The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.***
- [x] ***The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.***

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

A financial management services entity is used to make payments for in-home 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 may go to the dhhs website at www.scdhhs.gov/Providers for more information about billing Medicaid directly.

- [ ] ***Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.***

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. *Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:*

- (●) ***No. The state does not make supplemental or enhanced payments for waiver services.***
- ( ) ***Yes. The state makes supplemental or enhanced payments for waiver services.***

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS.

Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. *Specify whether state or local government providers receive payment for the provision of waiver services.*

- ○ ***No. State or local government providers do not receive payment for waiver services.*** *Do not complete Item I-3-e.*
- ◉ ***Yes. State or local government providers receive payment for waiver services.*** *Complete Item I-3-e.*

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

SCDDSN will receive payment for waiver services and will provide the following waiver services: respite care, environmental modifications, private vehicle modifications, assistive technology/appliances, career preparation, day activity, community services, support center services, in-home support, and employment services.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

- ○ ***The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.***
- ○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.***
- ◉ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.***

Describe the recoupment process:

Effective with the October 1, 2012 methodology revision, SCDDSN waiver services are paid prospectively. No supplemental payments are provided to SCDDSN subsequent to the claims payments. At fiscal year-end, a cost report is required that reflects the total costs incurred by SCDDSN and / or its local Boards for the discrete services provided under this waiver. SCDHHS reviews the cost report to substantiate CPE and to verify the actual expenditures of the individual services. Upon completion of the review, actual expenditures of the waiver, in the aggregate, are compared to total claims payment for the waiver (i.e. in the aggregate). If SCDDSN has been overpaid based on the aggregate comparison. SCDHHS will recoup the federal portion of the overpayment from SCDDSN and return it to CMS via the quarterly expenditure report. It should be noted that the comparison noted above is specific to each waiver operated by SCDDSN. That is the aggregation of expenditures and claims payments is made per waiver and does not consolidate all waivers together.

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. *Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:*

- (●) ***Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.***
- ( ) ***Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.***

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- ( ) ***No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.***
- (●) ***Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).***

Specify the governmental agency (or agencies) to which reassignment may be made.

The Department of Disabilities and Special Needs

ii. Organized Health Care Delivery System. *Select one:*

- ( ) ***No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.***
- (●) ***Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.***

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of

providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

(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 states procurement process. (e) DDSN assures that contracts with providers meet applicable requirements via quality assurance reviews of the provider, as well as periodic record reviews. (f) DDSN requires its local DSN County Boards to perform annual financial audits.

iii. Contracts with MCOs, PIHPs or PAHPs.

- (●) ***The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.***
- ( ) ***The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §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.***
- ( ) ***This waiver is a part of a concurrent ?1115/?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 ?1115 waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ( ) ***If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.***

  In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:*

☐ ***Appropriation of State Tax Revenues to the State Medicaid agency***

☒ ***Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.***

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

SCDDSN receives state appropriations to provide services under this waiver. A portion of these funds will be transferred to the SCDHHS via an IDT 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 state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:*

◉ ***Not Applicable****. There are no local government level sources of funds utilized as the non-federal share.*

○ ***Applicable***

Check each that applies:

☐ ***Appropriation of Local Government Revenues.***

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ ***Other Local Government Level Source(s) of Funds.***

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. *Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:*

- (●) ***None of the specified sources of funds contribute to the non-federal share of computable waiver costs***
- ( ) ***The following source(s) are used***

  Check each that applies:

  - [ ] ***Health care-related taxes or fees***
  - [ ] ***Provider-related donations***
  - [ ] ***Federal funds***

  For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

- (●) ***No services under this waiver are furnished in residential settings other than the private residence of the individual.***
- ( ) ***As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.***

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. *The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:*

Do not complete this item.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- (●) ***No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.***
- ( ) ***Yes. Per 42 CFR §441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D***

(cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. *Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:*

- (●) ***No. The state does not impose a co-payment or similar charge upon participants for waiver services.***
- ( ) ***Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.***

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- [ ] ***Nominal deductible***
- [ ] ***Coinsurance***
- [ ] ***Co-Payment***
- [ ] ***Other charge***

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. *Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:*

- (●) ***No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.***
- ( ) ***Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.***

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. *Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.*

Level(s) of Care: ICF/IID

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	9165.79	3766.00	12931.79	111354.00	4779.00	116133.00	103201.21
2	9619.10	3879.00	13498.10	114695.00	4923.00	119618.00	106119.90
3	10324.21	3996.00	14320.21	118136.00	5070.00	123206.00	108885.79
4	10824.76	4116.00	14940.76	121680.00	5223.00	126903.00	111962.24
5	11316.33	4239.00	15555.33	125330.00	5379.00	130709.00	115153.67

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. *Enter the total number of unduplicated participants from Item B-3-a who*

will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	
		ICF/IID	
Year 1	5800		5800
Year 2	6380		6380
Year 3	7020		7020
Year 4	7720		7720
Year 5	8500		8500

Appendix J: Cost Neutrality Demonstration

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

b. Average Length of Stay. *Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.*

The estimate of the average length of stay on the #0676 is based on an evaluation of trending CMS 372 report data, state legislative funding, waiting list reduction efforts, and projections of new enrollments and terminations. Terminations are based upon historical data, and enrollments are based upon growth models for the waiver program.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. *Provide a narrative description for the derivation of the estimates of the following factors.*

i. Factor D Derivation. *The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:*

The estimates of Factor D for #0676 are based on trending analysis of CMS 372 reports, participant and utilization information from the operating agency, state legislative funding, and waiting list reduction efforts. Based upon this review, the State is projecting continued growth over the next few years. While this is our projection the State recognizes that it will need to amend the waiver if growth exceeds projected levels. In projecting cost estimates the State runs the CMS 372 report approximately six months after the end of the waiver year to have interim data available for trending analysis. This is used internally to provide estimates based upon more recent data. The state implemented rate increases for adult day health, personal care I and II, career preparation, community services, day activity, employment services (group, in-home support and support center services). The changes to the Avg. Cost/Unit for WY3-5 estimates are based upon current rates and a 3% inflation factor. Also, these figures are based on only Medicaid expenditures and are therefore adjusted for Part D payment of prescription drugs. The rates are based upon current rates with a 3% inflation factor projected for each year after the first year of the waiver. It is recognized that many factors affect the actual change in rates. The 3% figure is used as our best current estimate while understanding that projections five years out are likely to be revised.

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 estimates of Factor D' for #0676 are based on trending analysis of CMS 372 reports, participant and utilization information from the operating agency, state legislative funding, and waiting list reduction efforts. Based upon this review, the State is projecting continued growth over the next few years. While this is our projection the State recognizes that it will need to amend the waiver if growth exceeds projected levels. In projecting cost estimates the State runs the CMS 372 report approximately six months after the end of the waiver year to have interim data available for trending analysis. This is used internally to provide estimates based upon more recent data. Also, these figures are based on only Medicaid expenditures and are therefore adjusted for Part D payment of prescription drugs. The rates are based upon current rates with a 3% inflation factor projected for each year after the first year of the waiver. It is recognized that many factors affect the actual change in rates. The 3% figure is used as our best current estimate while understanding that projections five years out are likely to be revised.

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:*

The estimates of Factor G for #0676 are based on trending analysis of institutional cost data, CMS 372 reports, and historical trends in South Carolina. In projecting cost estimates the State runs the CMS 372 report approximately six months after the end of the waiver year to have interim data available for trending analysis. This is used internally to provide estimates based upon more recent data. The rates are based upon current rates with a 3% inflation factor projected for each year after the first year of the waiver. However, it is recognized that individual factors will affect this figure. It represents the best efforts of the State to project five years into the future, with the understanding that any projections that far out will be refined over time based upon future data.

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 estimates of Factor G' for #0676 are based on trending analysis of institutional cost data, CMS 372 reports, and historical trends in South Carolina. In projecting cost estimates the State runs the CMS 372 report approximately six months after the end of the waiver year to have interim data available for trending analysis. This is used internally to provide estimates based upon more recent data. The rates are based upon current rates with a 3% inflation factor projected for each year after the first year of the waiver. However, it is recognized that individual factors will affect this figure. It represents the best efforts of the State to project five years into the future, with the understanding that any projections that far out will be refined over time based upon future data.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. *If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "manage components" to add these components.*

Waiver Services	
Adult Day Health Care Services	
Personal Care Services	
Respite Care Services	
Waiver Case Management (WCM)	
Incontinence Supplies	
Adult Day Health Care Nursing	
Adult Day Health Care Transportation	
Assistive Technology and Appliances Assessment/Consultation	
Assistive Technology and Appliances	
BEHAVIOR SUPPORT SERVICES	
CAREER PREPARATION SERVICES	
COMMUNITY SERVICES	

Waiver Services	
DAY ACTIVITY	
EMPLOYMENT SERVICES	
Environmental Modifications	
In-Home Support services	
Personal Emergency Response Systems (PERS)	
Private Vehicle Assessment/Consultation	
PRIVATE VEHICLE MODIFICATIONS	
SUPPORT CENTER SERVICES	

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Care Services Total:						900168.36
Adult Day Health Care Services	Day	102	169.00	52.22	900168.36	
Personal Care Services Total:						883036.08
Personal Care II	Hour	174	222.00	17.00	656676.00	
Personal Care I	Hour	87	222.00	11.72	226360.08	
Respite Care Services Total:						4034096.40
Non-Institutional Hourly	Hour	870	348.00	12.69	3842024.40	
Institutional Nursing Facility	Day	15	32.00	120.00	57600.00	
Institutional ICF/MR	Day	15	32.00	280.15	134472.00	
Waiver Case Management (WCM) Total:						10306600.00
Waiver Case Management - Without Travel	15 minute	5800	74.00	15.50	6652600.00	
Waiver Case Management - With Travel	15 minute	5800	25.00	25.20	3654000.00	
Incontinence Supplies						153120.00
GRAND TOTAL:						53161574.26
Total Estimated Unduplicated Participants:						5800
Factor D (Divide total by number of participants):						9165.79
Average Length of Stay on the Waiver:						321

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Total:						
Incontinence Supplies	month	174	11.00	80.00	153120.00	
Adult Day Health Care Nursing Total:						8977.50
Adult Day Health Care Nursing	Day	15	42.00	14.25	8977.50	
Adult Day Health Care Transportation Total:						245813.88
Adult Day Health Care Transportation	unit	102	338.00	7.13	245813.88	
Assistive Technology and Appliances Assessment/Consultation Total:						3000.00
Assistive Technology and Appliances Assessment/Consultation	unit	10	1.00	300.00	3000.00	
Assistive Technology and Appliances Total:						36000.00
Assistive Technology and Appliances	item	20	1.00	1800.00	36000.00	
BEHAVIOR SUPPORT SERVICES Total:						73080.00
BEHAVIOR SUPPORT SERVICES	half hour	29	84.00	30.00	73080.00	
CAREER PREPARATION SERVICES Total:						10533855.60
CAREER PREPARATION SERVICES	Unit	1740	222.00	27.27	10533855.60	
COMMUNITY SERVICES Total:						4877839.44
Community Services - Individual	unit	290	84.00	27.27	664297.20	
Community Services - Group	unit	696	222.00	27.27	4213542.24	
DAY ACTIVITY Total:						8075955.96
DAY ACTIVITY	Unit	1334	222.00	27.27	8075955.96	
EMPLOYMENT SERVICES Total:						11503209.60
Employment Services-Individual	Hour	522	222.00	87.80	10174615.20	
Employment Services-Group	Unit	1160	42.00	27.27	1328594.40	
Environmental Modifications Total:						217500.00
Environmental Modifications	Item	29	1.00	7500.00	217500.00	

GRAND TOTAL:	53161574.26
Total Estimated Unduplicated Participants:	5800
Factor D (Divide total by number of participants):	9165.79
Average Length of Stay on the Waiver:	321

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
In-Home Support services Total:						**475124.40**
In-Home Support services	Hour	174	222.00	12.30	**475124.40**	
Personal Emergency Response Systems (PERS) Total:						**10440.00**
Personal Emergency Response Systems (PERS) Installation	item	29	1.00	30.00	**870.00**	
Personal Emergency Response Systems (PERS) Monthly Monitoring	monthly	29	11.00	30.00	**9570.00**	
Private Vehicle Assessment/Consultation Total:						**9000.00**
Private Vehicle Assessment/Consultation	unit	15	1.00	600.00	**9000.00**	
PRIVATE VEHICLE MODIFICATIONS Total:						**112500.00**
PRIVATE VEHICLE MODIFICATIONS	Item	15	1.00	7500.00	**112500.00**	
SUPPORT CENTER SERVICES Total:						**702257.04**
SUPPORT CENTER SERVICES	Unit	116	222.00	27.27	**702257.04**	
				GRAND TOTAL:		**53161574.26**
				Total Estimated Unduplicated Participants:		**5800**
				Factor D (Divide total by number of participants):		**9165.79**
				Average Length of Stay on the Waiver:		321

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Care Services Total:						**1036210.56**
Adult Day Health Care Services	Day	112	172.00	53.79	**1036210.56**	
Personal Care Services Total:						**1017707.38**
				GRAND TOTAL:		**61369831.37**
				Total Estimated Unduplicated Participants:		**6380**
				Factor D (Divide total by number of participants):		**9619.10**
				Average Length of Stay on the Waiver:		327

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Care II	Hour	191	226.00	17.51	755836.66	
Personal Care I	Hour	96	226.00	12.07	261870.72	
Respite Care Services Total:						4651357.25
Non-Institutional Hourly	Hour	957	355.00	13.07	4440336.45	
Institutional Nursing Facility	Day	16	32.00	123.60	63283.20	
Institutional ICF/MR	Day	16	32.00	288.55	147737.60	
Waiver Case Management (WCM) Total:						11947889.80
Waiver Case Management - Without Travel	15 minute	6380	75.00	15.97	7641645.00	
Waiver Case Management - With Travel	15 minute	6380	26.00	25.96	4306244.80	
Incontinence Supplies Total:						173122.40
Incontinence Supplies	month	191	11.00	82.40	173122.40	
Adult Day Health Care Nursing Total:						10099.84
Adult Day Health Care Nursing	Day	16	43.00	14.68	10099.84	
Adult Day Health Care Transportation Total:						282795.52
Adult Day Health Care Transportation	unit	112	344.00	7.34	282795.52	
Assistive Technology and Appliances Assessment/Consultation Total:						3399.00
Assistive Technology and Appliances Assessment/Consultation	unit	11	1.00	309.00	3399.00	
Assistive Technology and Appliances Total:						40788.00
Assistive Technology and Appliances	item	22	1.00	1854.00	40788.00	
BEHAVIOR SUPPORT SERVICES Total:						85036.80
BEHAVIOR SUPPORT SERVICES	half hour	32	86.00	30.90	85036.80	
CAREER PREPARATION SERVICES Total:						12150722.76
CAREER PREPARATION SERVICES	Unit	1914	226.00	28.09	12150722.76	

GRAND TOTAL:	61369831.37
Total Estimated Unduplicated Participants:	6380
Factor D (Divide total by number of participants):	9619.10
Average Length of Stay on the Waiver:	327

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
COMMUNITY SERVICES Total:						**5633449.50**
Community Services - Individual	Unit	319	86.00	28.09	**770621.06**	
Community Services - Group	Unit	766	226.00	28.09	**4862828.44**	
DAY ACTIVITY Total:						**9313014.78**
DAY ACTIVITY	Unit	1467	226.00	28.09	**9313014.78**	
EMPLOYMENT SERVICES Total:						**13272183.44**
Employment Services-Individual	Hour	574	226.00	90.43	**11730941.32**	
Employment Services-Group	Unit	1276	43.00	28.09	**1541242.12**	
Environmental Modifications Total:						**247200.00**
Environmental Modifications	Item	32	1.00	7725.00	**247200.00**	
In-Home Support services Total:						**546913.22**
In-Home Support services	Hour	191	226.00	12.67	**546913.22**	
Personal Emergency Response Systems (PERS) Total:						**11865.60**
Personal Emergency Response Systems (PERS) Installation	item	32	1.00	30.90	**988.80**	
Personal Emergency Response Systems (PERS) Monthly Monitoring	monthly	32	11.00	30.90	**10876.80**	
Private Vehicle Assessment/Consultation Total:						**9888.00**
Private Vehicle Assessment/Consultation	unit	16	1.00	618.00	**9888.00**	
PRIVATE VEHICLE MODIFICATIONS Total:						**123600.00**
PRIVATE VEHICLE MODIFICATIONS	Item	16	1.00	7725.00	**123600.00**	
SUPPORT CENTER SERVICES Total:						**812587.52**
SUPPORT CENTER SERVICES	Unit	128	226.00	28.09	**812587.52**	

GRAND TOTAL:	**61369831.37**
Total Estimated Unduplicated Participants:	**6380**
Factor D (Divide total by number of participants):	**9619.10**
Average Length of Stay on the Waiver:	327

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Care Services Total:						1250387.25
Adult Day Health Care Services	Day	123	175.00	58.09	1250387.25	
Personal Care Services Total:						1268371.80
Personal Care II	Hour	211	230.00	18.96	920128.80	
Personal Care I	Hour	105	230.00	14.42	348243.00	
Respite Care Services Total:						5368755.06
Non-Institutional Hourly	Hour	1053	361.00	13.46	5116590.18	
Institutional Nursing Facility	Day	18	33.00	127.31	75622.14	
Institutional ICF/MR	Day	18	33.00	297.21	176542.74	
Waiver Case Management (WCM) Total:						12977874.00
Waiver Case Management - Without Travel	15 minute	7020	77.00	15.50	8378370.00	
Waiver Case Management - With Travel	15 minute	7020	26.00	25.20	4599504.00	
Incontinence Supplies Total:						196983.27
Incontinence Supplies	month	211	11.00	84.87	196983.27	
Adult Day Health Care Nursing Total:						11975.04
Adult Day Health Care Nursing	Day	18	44.00	15.12	11975.04	
Adult Day Health Care Transportation Total:						325458.00
Adult Day Health Care Transportation	unit	123	350.00	7.56	325458.00	
Assistive Technology and Appliances Assessment/Consultation Total:						3819.24
Assistive Technology					3819.24	

GRAND TOTAL:	72475960.39
Total Estimated Unduplicated Participants:	7020
Factor D (Divide total by number of participants):	10324.21
Average Length of Stay on the Waiver:	333

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
and Appliances Assessment/Consultation	unit	12	1.00	318.27		
Assistive Technology and Appliances Total:						47740.50
Assistive Technology and Appliances	item	25	1.00	1909.62	47740.50	
BEHAVIOR SUPPORT SERVICES Total:						98036.40
BEHAVIOR SUPPORT SERVICES	half hour	35	88.00	31.83	98036.40	
CAREER PREPARATION SERVICES Total:						14962498.20
CAREER PREPARATION SERVICES	Unit	2106	230.00	30.89	14962498.20	
COMMUNITY SERVICES Total:						6936287.72
Community Services - Individual	Unit	351	88.00	30.89	954130.32	
Community Services - Group	Unit	842	230.00	30.89	5982157.40	
DAY ACTIVITY Total:						11474090.50
DAY ACTIVITY	Unit	1615	230.00	30.89	11474090.50	
EMPLOYMENT SERVICES Total:						15447091.04
Employment Services-Individual	Hour	632	230.00	93.14	13538830.40	
Employment Services-Group	Unit	1404	44.00	30.89	1908260.64	
Environmental Modifications Total:						278486.25
Environmental Modifications	Item	35	1.00	7956.75	278486.25	
In-Home Support services Total:						665346.30
In-Home Support services	Hour	211	230.00	13.71	665346.30	
Personal Emergency Response Systems (PERS) Total:						13368.60
Personal Emergency Response Systems (PERS) Installation	item	35	1.00	31.83	1114.05	
Personal Emergency Response Systems (PERS) Monthly Monitoring	monthly	35	11.00	31.83	12254.55	
Private Vehicle Assessment/Consultation Total:						11457.72

GRAND TOTAL:	72475960.39
Total Estimated Unduplicated Participants:	7020
Factor D (Divide total by number of participants):	10324.21
Average Length of Stay on the Waiver:	333

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Private Vehicle Assessment/Consultation	unit	18	1.00	636.54	11457.72	
PRIVATE VEHICLE MODIFICATIONS Total:						143275.50
PRIVATE VEHICLE MODIFICATIONS	Item	18	1.00	7959.75	143275.50	
SUPPORT CENTER SERVICES Total:						994658.00
SUPPORT CENTER SERVICES	Unit	140	230.00	30.89	994658.00	
				GRAND TOTAL:		72475960.39
				Total Estimated Unduplicated Participants:		7020
				Factor D (Divide total by number of participants):		10324.21
				Average Length of Stay on the Waiver:		333

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Care Services Total:						1437714.90
Adult Day Health Care Services	Day	135	178.00	59.83	1437714.90	
Personal Care Services Total:						1462790.16
Personal Care II	hour	232	234.00	19.52	1059701.76	
Personal Care I	Hour	116	234.00	14.85	403088.40	
Respite Care Services Total:						6180517.86
Non-Institutional Hourly	Hour	1158	368.00	13.86	5906355.84	
Institutional Nursing Facility	Day	19	33.00	131.13	82218.51	
Institutional ICF/MR	Day	19	33.00	306.13	191943.51	
Waiver Case Management (WCM) Total:						15019491.60
				GRAND TOTAL:		83567170.94
				Total Estimated Unduplicated Participants:		7720
				Factor D (Divide total by number of participants):		10824.76
				Average Length of Stay on the Waiver:		339

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Waiver Case Management - Without Travel	15 minute	7720	78.00	15.96	9610473.60	
Waiver Case Management - With Travel	15 minute	7720	27.00	25.95	5409018.00	
Incontinence Supplies Total:						223095.84
Incontinence Supplies	month	232	11.00	87.42	223095.84	
Adult Day Health Care Nursing Total:						13312.35
Adult Day Health Care Nursing	Day	19	45.00	15.57	13312.35	
Adult Day Health Care Transportation Total:						373906.80
Adult Day Health Care Transportation	unit	135	356.00	7.78	373906.80	
Assistive Technology and Appliances Assessment/Consultation Total:						4589.48
Assistive Technology and Appliances Assessment/Consultation	unit	14	1.00	327.82	4589.48	
Assistive Technology and Appliances Total:						53106.57
Assistive Technology and Appliances	item	27	1.00	1966.91	53106.57	
BEHAVIOR SUPPORT SERVICES Total:						113779.38
BEHAVIOR SUPPORT SERVICES	half hour	39	89.00	32.78	113779.38	
CAREER PREPARATION SERVICES Total:						17244658.08
CAREER PREPARATION SERVICES	Unit	2316	234.00	31.82	17244658.08	
COMMUNITY SERVICES Total:						7988029.16
Community Services - Individual	Per Unit	386	89.00	31.82	1093144.28	
Community Services - Group	Per Unit	926	234.00	31.82	6894884.88	
DAY ACTIVITY Total:						13223882.88
DAY ACTIVITY	Unit	1776	234.00	31.82	13223882.88	
EMPLOYMENT SERVICES Total:						17811949.50
Employment Services-Individual	Hour	695	234.00	95.93	15601095.90	

GRAND TOTAL:	83567170.94
Total Estimated Unduplicated Participants:	7720
Factor D (Divide total by number of participants):	10824.76
Average Length of Stay on the Waiver:	339

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Employment Services-Group	Unit	1544	45.00	31.82	2210853.60	
Environmental Modifications Total:						319622.55
Environmental Modifications	Item	39	1.00	8195.45	319622.55	
In-Home Support services Total:						766546.56
In-Home Support services	Hour	232	234.00	14.12	766546.56	
Personal Emergency Response Systems (PERS) Total:						15341.04
Personal Emergency Response Systems (PERS) Installation	item	39	1.00	32.78	1278.42	
Personal Emergency Response Systems (PERS) Monthly Monitoring	monthly	39	11.00	32.78	14062.62	
Private Vehicle Assessment/Consultation Total:						12457.16
Private Vehicle Assessment/Consultation	unit	19	1.00	655.64	12457.16	
PRIVATE VEHICLE MODIFICATIONS Total:						155713.55
PRIVATE VEHICLE MODIFICATIONS	Item	19	1.00	8195.45	155713.55	
SUPPORT CENTER SERVICES Total:						1146665.52
SUPPORT CENTER SERVICES	Unit	154	234.00	31.82	1146665.52	
				GRAND TOTAL:		83567170.94
				Total Estimated Unduplicated Participants:		7720
				Factor D (Divide total by number of participants):		10824.76
				Average Length of Stay on the Waiver:		339

Appendix J: Cost Neutrality Demonstration

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

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Care Services Total:						**1661829.78**
Adult Day Health Care Services	Day	149	181.00	61.62	**1661829.78**	
Personal Care Services Total:						**1686270.46**
Personal Care II	Hour	255	238.00	20.11	**1220475.90**	
Personal Care I	Hour	128	238.00	15.29	**465794.56**	
Respite Care Services Total:						**7130982.18**
Non-Institutional Hourly	Hour	1275	374.00	14.28	**6809418.00**	
Institutional Nursing Facility	Day	21	34.00	135.06	**96432.84**	
Institutional ICF/MR	Day	21	34.00	315.31	**225131.34**	
Waiver Case Management (WCM) Total:						**17176290.00**
Waiver Case Management - Without Travel	15 minute	8500	79.00	16.44	**11039460.00**	
Waiver Case Management - With Travel	15 minute	8500	27.00	26.74	**6136830.00**	
Incontinence Supplies Total:						**252562.20**
Incontinence Supplies	month	255	11.00	90.04	**252562.20**	
Adult Day Health Care Nursing Total:						**15157.80**
Adult Day Health Care Nursing	Day	21	45.00	16.04	**15157.80**	
Adult Day Health Care Transportation Total:						**432043.38**
Adult Day Health Care Transportation	unit	149	362.00	8.01	**432043.38**	
Assistive Technology and Appliances Assessment/Consultation Total:						**5064.75**
Assistive Technology and Appliances Assessment/Consultation	unit	15	1.00	337.65	**5064.75**	
Assistive Technology and Appliances Total:						**60777.60**
Assistive Technology and Appliances	item	30	1.00	2025.92	**60777.60**	
BEHAVIOR SUPPORT SERVICES Total:						**132102.88**

GRAND TOTAL:	**96188766.29**
Total Estimated Unduplicated Participants:	**8500**
Factor D (Divide total by number of participants):	**11316.33**
Average Length of Stay on the Waiver:	345

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
BEHAVIOR SUPPORT SERVICES	half hour	43	91.00	33.76	132102.88	
CAREER PREPARATION SERVICES Total:						19888113.00
CAREER PREPARATION SERVICES	Unit	2550	238.00	32.77	19888113.00	
COMMUNITY SERVICES Total:						9222624.95
Community Services - Individual	unit	425	91.00	32.77	1267379.75	
Community Services - Group	unit	1020	238.00	32.77	7955245.20	
DAY ACTIVITY Total:						15247553.30
DAY ACTIVITY	Unit	1955	238.00	32.77	15247553.30	
EMPLOYMENT SERVICES Total:						20497241.70
Employment Services-Individual	Hour	765	238.00	98.81	17990336.70	
Employment Services-Group	Unit	1700	45.00	32.77	2506905.00	
Environmental Modifications Total:						362976.33
Environmental Modifications	Item	43	1.00	8441.31	362976.33	
In-Home Support services Total:						882432.60
In-Home Support services	Hour	255	238.00	14.54	882432.60	
Personal Emergency Response Systems (PERS) Total:						17420.16
Personal Emergency Response Systems (PERS) Installation	item	43	1.00	33.76	1451.68	
Personal Emergency Response Systems (PERS) Monthly Monitoring	monthly	43	11.00	33.76	15968.48	
Private Vehicle Assessment/Consultation Total:						14181.51
Private Vehicle Assessment/Consultation	unit	21	1.00	675.31	14181.51	
PRIVATE VEHICLE MODIFICATIONS Total:						177267.51
PRIVATE VEHICLE MODIFICATIONS	Item	21	1.00	8441.31	177267.51	
SUPPORT CENTER SERVICES Total:						1325874.20

GRAND TOTAL:	96188766.29
Total Estimated Unduplicated Participants:	8500
Factor D (Divide total by number of participants):	11316.33
Average Length of Stay on the Waiver:	345

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
SUPPORT CENTER SERVICES	Unit	170	238.00	32.77	1325874.20	
				GRAND TOTAL:		96188766.29
				Total Estimated Unduplicated Participants:		8500
				Factor D (Divide total by number of participants):		11316.33
				Average Length of Stay on the Waiver:		345