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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:
* Revisions necessary to meet HCBS Final Rule requirements

* Allowing exceptions to service limits in special circumstances to prevent institutionalization

* Additional reserve capacity for military personnel (per state legislation) and individuals being discharged from nursing facilities

* Removal of prescription drug benefit

* Establishment of a separate consultation service for both vehicle modifications and assistive technology (per CMS direction)

* Addition of pest control and bed bug treatment services

* Level of care criteria revision

* Quality Performance Measure updates

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

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*):
Head and Spinal Cord Injury (HASCI) Waiver

C. Type of Request: renewal

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**

Original Base Waiver Number: SC.0284
Waiver Number:SC.0284.R05.00
Draft ID: SC.009.05.00

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

Regular Waiver

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

07/01/18

Approved Effective Date: 07/01/18

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**

- [x] **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**

- [x] **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:

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.
The Head and Spinal Cord Injury Waiver serves persons with traumatic brain injury, spinal cord injury, or both, or a similar disability not associated with the process of a progressive degenerative illness, disease, dementia or a neurological disorder related to aging. The services offered in this waiver are meant to prevent and/or delay institutionalization in a nursing home or ICF/IID. All participants must meet either the Nursing Facility Level of Care or the ICF/IID Level of Care criteria.

The South Carolina Department of Health and Human Services (DHHS) has administrative authority over this waiver. The South Carolina Department of Disabilities and Special Needs (DDSN) operates the waiver under administrative and service contracts with DHHS. DDSN utilizes an organized health care delivery system that includes both county disability and special needs boards as well as private providers. Services in this waiver are provided at the local level mainly through a traditional service delivery system. This waiver also has a participant-directed attendant care service. DDSN is responsible for ensuring that waiver participants are aware of their options for receiving services both through this waiver and outside of it.

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:
Public forums were held across the state to collect input from waiver participants, their families/representatives, community agencies serving waiver participants, disability boards and other stakeholders on the following dates:

September 19, 2017 (Columbia, South Carolina)
September 20, 2017 (Florence, South Carolina)
September 21, 2017 (Charleston, South Carolina)
September 26, 2017 (Greenville, South Carolina)

Additionally, meetings were held with the following entities to give them an opportunity to provide input on behalf of their constituents:

The Brain Injury Association of South Carolina
The Spinal Cord Injury Association of South Carolina
Thrive Upstate
Family Connections
Protection and Advocacy

In November of 2017, proposed waiver renewal changes were reviewed with the DHHS Medical Care Advisory Committee (MCAC) and representatives of tribal governments. In May of 2018, updated information was shared with the DHHS MCAC.

Based on the input received and other considerations, DHHS determined what program changes would be proposed in this renewal and what program changes would be studied further.

In February and March of 2018, the public notice process was executed. This included posting the waiver document to the DHHS website and making it available for review in physical form throughout the state. Respondents could deliver feedback electronically or via mail.

Subsequently, an additional 30-day public notice process was carried out during May and June of 2018 following the same steps as described above.

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: Robinson

First Name: Jennifer

Title: Waiver Administrator

Agency: SC Department of Health and Human Services

Address: PO Box 8206

Address 2:

City: Columbia

State: **South Carolina**

Zip: 29202

Phone: (803) 898-0563 **Ext:** ☐ **TTY**

Fax: (803) 255-8204

E-mail: Jennifer.Robinson@scdhhs.gov

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

Last Name: Ritter

First Name: Melissa

Title: Director, Head and Spinal Cord Injury Division

Agency: SC Department of Disabilities and Special Needs

Address: PO Box 4706

Address 2: Harden St. Ext.

City: Columbia

State: **South Carolina**

Zip: 29240

Phone: (803) 898-5120 **Ext:** ☐ **TTY**

Fax: (803) 898-9653

E-mail: MRitter@ddsn.sc.gov

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the State's request for a waiver under §1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.
Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature: Joshua Baker

State Medicaid Director or Designee

Submission Date: Sep 11, 2018

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 Head

Agency: South Carolina Department of Health and Human Services

Address: P.O. Box 8206

Address 2:

City: Columbia

State: **South Carolina**

Zip: 29202

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

Fax: (803) 898-4515

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:

The prescribed drugs service is being eliminated. Effective July 1, 2017, SCDHHS amended the South Carolina Title XIX State Plan to remove the limitation that adult beneficiaries only receive four prescriptions per month. As a result, the prescribed drugs waiver service is redundant. Waiver participants will not be adversely impacted.

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.

The state ensures that the setting transition plan included with this waiver renewal will be subject to any provisions or requirements included in the state's approved Statewide Transition Plan (STP). The state will implement any required changes upon approval of the STP and will make conforming changes to its waiver when it submits the next amendment or renewal. The STP can be found here: https://msp.scdhhs.gov/hcbs/sites/default/files/SC%20Statewide%20Transition%20Plan%20-%20CMS%20Submission%2011-3-2016.pdf

DHHS submitted a transition plan to CMS as part of the state's ID/RD Waiver renewal approved in 2017. Settings used by HASCI participants are a subset of the settings used by ID/RD participants.

On November 3, 2016, DHHS received initial approval of its Statewide Transition Plan (STP) from CMS covering all waiver programs affected by the HCBS Final Rule, including the HASCI Waiver.

The following activities have been completed:
* Systemic review of policies, standards, regulations, etc.
* Provider self-assessments
* Settings assessments
* Distribution of findings to providers

The following activities are under way:
* Revisions to policies, standards, etc. based on systemic review
* Provider corrective action plan development
* Execution of provider corrective actions
* Preparation of revised STP for public notice issuance
* Preparation of milestone status report

For reference, here is a summary of the settings utilized by HASCI participants:

RESIDENTIAL
Community Training Home (CTH I/CTH-II) - 42 participants
Supervised Living Program II (SLP II) - 5 participants
Supervised Living Program I (SLP I) - 2 participants
Community Residential Care Facility (CRCF) - 1 participant

DAY SERVICES
Day Activity Services - 23 participants
Employment Services - 16 participants
Career Preparation Services - 13 participants

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

SUMMARY OF PUBLIC INPUT RECEIVED

Below is a summary of the relevant public input received as part of the February/March 2018 public notice process.

General Comments:
• A participant reported they "would have nowhere to go" if they didn't receive the services they get through the waiver
• Support for proposed pest control services
• The waiver document is complicated and difficult to follow
• Concerns about timeliness in receiving services, transparency around operational budgets, and the number of participants served
• Support for allowing service limit exceptions
• Concerns regarding challenges waiver participants face in gaining access to transportation

Level of Care (LOC) Comments:
• Respondent explained that they have been advocating for new criteria to enter the waiver, and they felt that the changes to the LOC criteria would address their concerns
• Respondent thanked SCDHHS and DDSN for hosting public forums and utilizing the feedback to make "positive changes" in the LOC
• Respondent stated the new LOC is "a move in the right direction"
• Respondents shared their appreciation for the LOC changes and believed that these changes would have a tremendous impact on the lives of people who were not previously eligible to receive services
• Respondents reported changes would not only have a positive effect on participants, but their families as well
• Respondents stated this change was something the TBI community have been advocating and they were excited to see we had listened to public feedback
• Respondent asked for further explanation of the level of care. Due to the title "HASCI At-Risk for Hospitalization Level of Care" he/she expressed concern that it would be more restrictive
• Respondent hoped changes would be implemented quickly
• Respondent described changes as truly addressing the challenges that individuals with TBI face, and, as a result, it appeared the State had an excellent understanding of this disability
• Respondents shared support for including "cognitive, memory and behavioral" issues in the new LOC - "physical issues are often easier to compensate for than mental."
• Respondents stated that these changes would allow for more community integration and acceptance for individuals
• Respondent stated there was no anticipated "downside" to the LOC changes
• Respondent expressed concern that CMS would not approve the new level of care and they hoped that would not be the case
• Respondent stated "keep up the good work SCDHHS!"

As shown above, the feedback was largely positive. Opportunities for improvement gathered from this process not addressed in this renewal will be considered in the future.

No relevant comments were received during the May/June public notice process.

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

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 has executed a memorandum of agreement (MOA) with DDSN documenting its responsibilities in the areas of communication, coordination, level of care determinations, quality management, information technology, fiscal and other administration. The MOA is reviewed and updated at least every five (5) years and amended as needed.

   DHHS has also executed a number of service contracts with DDSN outlining its responsibilities related to the provision of waiver services. These contracts cover waiver service definitions, provider qualifications, reimbursement rates, conditions for reimbursement, and reporting. Service contracts are reviewed and updated at least every five (5) years and amended as needed.

   DHHS utilizes various quality assurance methods to evaluate DDSN's compliance with the MOA and service contracts, with special focus on DDSN's performance of assigned waiver operational and administrative functions in accordance with waiver requirements. DHHS uses Quality Improvement Organizations (QIOs), internal quality assurance (QA) staff, and other agency staff to continuously evaluate DDSN's performance. The role of each resource is described below.

   QIO: Conducts validation reviews of 100% of adverse initial level of care determinations performed by DDSN. Reports are produced and shared with DDSN, who is required to take remedial action as appropriate.

   DHHS QA staff: Conduct 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 take remedial action as appropriate. In addition, staff utilize agency IT systems to monitor DDSN's performance and compliance with waiver standards. Special focused reviews are executed as necessary. In such instances, a report of findings is provided to DDSN, who is required to implement corrective actions as appropriate.

   Other DHHS staff: Conduct utilization reviews, investigate potential fraud, and execute focused reviews as

necessary to monitor DDSN's performance. Any findings are shared with DDSN, who is required to take corrective action as appropriate.

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.:*
   USC School of Medicine: Performs quality assurance of University Affiliated Program (UAP) activities supporting self-directed or designated responsible party-directed attendant care services.

   CMS-certified QIO: Performs quality assurance reviews of waiver services and providers.

   Jasper & Charles Lea DSN Boards: Verifies qualifications of and executes payment to self-directed attendant care providers and respite.

   ( ) **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:

   [x] **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:

   Local Disabilities and Special Needs (DSN) Boards: These are governmental and/or quasi-governmental entities typically based out of a particular county. They provide case management and direct services. They also complete level of care re-evaluations; develop plans of service; and, perform other administrative tasks.

   Jasper DSN Board: Operates as fiscal agent for the UAP Self-Directed Attendant Care Program.

   [x] **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:

   Approved/qualified private providers: Provide case management and direct services. They also complete level of care re-evaluations; develop plans of service; and, perform other administrative tasks.

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:

DHHS and DDSN share the responsibility for assessing the performance of contracted and/or local/regional non-state entities. A MOA and contracts between DHHS and DDSN specify responsibilities in detail.

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 performance of contracted and/or local/regional non-state entities responsible for conducting waiver operational and administrative functions are assessed as follows:

* DDSN's Central Office conducts reviews of, and provides technical assistance to, the DSN Boards.

* DDSN's Internal Audit Division conducts reviews of the DSN Boards and other approved providers. It also conducts special request audits, investigates fraud cases, provides training and technical assistance, and reviews the audited financial statements of the DSN Boards. DSN Boards are required to conduct an annual financial audit through a CPA firm. Lastly, DDSN's Internal Audit Division reviews the contracted fiscal agent. DHHS reviews and acts upon DDSN Internal Audit Division findings as necessary.

* DDSN''s QIO assesses the DSN Boards and other approved providers on a twelve to eighteen month cycle based on each provider's past performance. The QIO also conducts follow-up reviews as warranted. QIO findings are shared with DHHS.

* DHHS utilizes a QIO to conduct validation reviews of representative samples of initial level of care determinations performed by DDSN (and its sub-contractors). Quarterly reports are produced and shared with DDSN, who is required to take remedial action as appropriate.

* DHHS internal QA staff conduct periodic focus reviews to ensure DDSN's (and its sub-contractors') operational and administrative activities conform to expectations. Findings are shared with DDSN, who is required to take remedial action as appropriate.

* DHHS staff also conduct utilization reviews, investigate potential fraud, and execute focused reviews as necessary to monitor DDSN's performance. Findings are shared with DDSN, who is required to take corrective action as appropriate.

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	☑	☑	☑	☑
Qualified provider enrollment	☑	☑	☑	☑

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
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 State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

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

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:
DDSN waiver operation compliance N = Number of focus reviews with findings;/ D = total number of focus reviews conducted

Data Source (Select one):
Other
If 'Other' is selected, specify:
DHHS Reviews

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

		Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: Sampling is determined by nature of focus review
	☑ **Other** Specify: Periodically based on nature of focus review strategy	

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: Periodically based on nature of focus review strategy

Performance Measure:
DDSN compliance with policy change approval process N = number of waiver policy changes approved by DHHS prior to implementation;/ D = all waiver changes implemented

Data Source (Select one):
Other
If 'Other' is selected, specify:
DHHS Policy Changes 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:

Performance Measure:
DDSN QIO Review 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, 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:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: As appropriate for nature of review
	☑ **Other** Specify: Periodically based on other reviews occurring	

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:

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

DHHS produces reports of findings based on reviews. These reports are shared with DDSN so they may develop and implement corrective action plans as appropriate. Corrective actions may include training, policy revisions and/or financial adjustments for Federal Financial Participation.

ii. Remediation Data Aggregation

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

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

c. Timelines

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)**	0	64	
	☑	**Disabled (Other)**	0	64	
☐ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	**Brain Injury**			☐
	☐	**HIV/AIDS**			☐
	☐	**Medically Fragile**			☐

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
	☐	Technology Dependent			☐
☐ Intellectual Disability or Developmental Disability, or Both					
	☐	Autism			☐
	☐	Developmental Disability			☐
	☐	Intellectual Disability			☐
☐ Mental Illness					
	☐	Mental Illness			☐
	☐	Serious Emotional Disturbance			

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

Participants must be enrolled prior to age 65 but will remain eligible for waiver services after their 65th birthday if all other eligibility factors continue to be met. Waiver services are limited to participants with traumatic brain injury, spinal cord injury or both or a similar disability not associated with the process of a progressive, degenerative illness, disease, dementia, or a neurological disorder related to aging, regardless of the age of onset where the individual:

1. Has urgent circumstances affecting his/her health or functional status; and,
2. Is dependent on others to provide or assist with critical health needs, basic activities of daily living or requires daily monitoring or supervision in order to avoid institutionalization; and,
3. Needs services not otherwise available within existing community resources, including family, private means and other agencies/programs, or for whom current resources are inadequate to meet the basic needs of the individual, which would allow them to remain in the community.

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:

Participants in the HASCI Waiver before age 65 remain eligible for waiver services after their 65th birthday if all other eligibility factors continue to be met. If an individual is affected by the age limit, his/her case manager assists with referrals to other community programs and/or waivers.

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.

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:

Appendix B: Participant Access and Eligibility

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

Answers provided in Appendix B-2-a indicate that you do not need to complete this section.

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:

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:

- [ ] **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	1070
Year 2	1126
Year 3	1185
Year 4	1247
Year 5	1312

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	1030
Year 2	1086
Year 3	1145
Year 4	1207
Year 5	1272

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
Military personnel and individuals discharged from nursing facilities

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):*

Military personnel and individuals discharged from nursing facilities

Purpose *(describe):*

Military Personnel

* Eligible family members of a member of the armed services who maintain a South Carolina residence, regardless of where the service member is stationed, will continue his/her waiver status.

* A family member on the waiting list when the family relocates outside of South Carolina returns to the same place on that list when the family returns to South Carolina.

* An eligible family member enrolled in the waiver program when the family relocates outside of South Carolina 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.

Individuals Discharged from Nursing Facilities

* This will allow individuals being discharged from a nursing facility to be served in the least restrictive setting and provide for community integration in a timely manner.

Describe how the amount of reserved capacity was determined:

The amount of reserved capacity is based on previous utilization for nursing facility discharges and projections for the military.

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 (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:

Responses in B-1, B-4 and B-6 describe the entrance criteria. As there is no waiting list, processing of applicants begins shortly after referral.

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)

- [x] **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:

- [x] **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)**
- [x] **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 spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**
☐ **Medically needy without spend down in 209(b) States (42 CFR §435.330)**
☐ **Aged and disabled individuals who have income at:**

Select one:

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

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 five-year period beginning January 1, 2014, 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 December 31, 2018.

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

* Eyeglasses not otherwise covered by the Medicaid program, not to exceed a total of $108 per occurrence for lenses, frames and dispensing fee. A licensed optometrist or ophthalmologist must certify the necessity of eyeglasses.

* A one-time expense not to exceed $651.00 per plate or $1320.00 for one full pair of dentures. A licensed dental practitioner must certify necessity. An expense for more than one pair of dentures must be prior approved by DHHS.

* Denture repair justified as necessary by a licensed dental practitioner not to exceed $69 per visit.

* Physician and other medical practitioner visits that exceed the yearly limit, not to exceed $69 per visit.

* A one-time expense for hearing aids not to exceed $1000.00 for one or $2000.00 for both. Necessity must be certified by a licensed practitioner. An expense for more than one hearing aid must be prior approved by DHHS.

* The deduction for medical and remedial care expenses that were incurred as the result of imposition of a transfer of assets penalty is limited to zero.

* Reasonable and necessary medical and remedial care expenses not covered by Medicaid incurred in the 3 months prior to the month of application are allowable deductions. Expenses incurred prior to this three-month period are not allowable deductions.

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:

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

- ○ **Directly by the Medicaid agency**
- ○ **By the operating agency specified in Appendix A**
- ○ **By an entity under contract with the Medicaid agency.**

Specify the entity:

- ◉ **Other**

Specify:

All initial NF Level of Care evaluations are performed by the Medicaid agency (DHHS). All initial ICF Level of Care evaluations are performed by the operating agency specified in Appendix A. All NF Level of Care and ICF Level of Care reevaluations are performed by the operating agency specified in Appendix A.

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:

NF Level of Care:

Registered Nurses licensed by the state or Licensed Practical Nurses working under the auspices of a Registered Nurse.

ICF Level of Care:

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

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

Initially, an applicant's situation is reviewed to determine if he/she is a member of the target population of the waiver. An applicant is a member of the target population when, at the time of determining eligibility, he/she has a severe chronic limitation that:

1. is attributed to a physical impairment including head injury, spinal cord injury, or both, or a similar disability, regardless of the age of onset not associated with the process of a progressive degenerative illness or disease, dementia, or a neurological disorder related to aging;

2. is likely to continue indefinitely without intervention;

3. results in substantial functional limitations in at least two of these life activities:
   a. self-care;
   b. receptive and expressive communication;

c. learning;
d. mobility;
e. self-direction;
f. capacity for independent living;
g. economic self-sufficiency; and

4. reflects the person's need for a combination and sequence of special interdisciplinary or generic care or treatment or other services, which are of lifelong or extended duration and are individually planned and coordinated.

After it is established that the applicant meets the target population for the waiver, either the NF Level of Care or ICF Level of Care (LOC) criteria are used to evaluate/reevaluate whether an individual qualifies for services through the waiver.

ICF Level of Care

The South Carolina ICF level of care criteria states that eligibility for Medicaid-sponsored ICF services 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 sub average 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 intellectual disability 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 intellectual disability because this condition results in impairment similar to that of persons with intellectual disability and requires treatment or services similar to those required for these persons.
• It is manifested before twenty-two years of age.
• It is likely to continue indefinitely.
• It results in substantial functional limitations in three or more of the following areas of major life activity: self-care, understanding and use of language, learning, mobility, self-direction and capacity for independent living.

AND

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

AND

3. The person is in need of services directed toward a) the acquisition of the behaviors necessary to function with as much self-determination and independence as possible; or b) the prevention or deceleration of loss of current optimal functional status.

NF Level of Care:

An applicant qualifies for waiver services through the NF LOC assessment in the following ways:
1. The applicant is totally dependent in all activities of daily living (ADL).
2. The applicant requires at least one skilled medical service and has at least one functional deficit in ADL.
3. The applicant has at least two functional deficits in ADL.
4. The applicant has at least one functional deficit in ADL and at least one of the following service needs, or, specifically for the purpose of gaining entry to the HASCI Waiver, the applicant has at least two of the following service needs:
a. Daily monitoring of a significant medical condition requiring overall care planning in order to maintain optimum health.
b. Supervision of moderate/severe memory issues, either long or short term, manifested by disorientation, bewilderment, and forgetfulness, which requires significant intervention in care planning.
c. Supervision of moderately impaired cognitive skills manifested by decisions which may reasonably be expected to affect an individual's safety.

d. Supervision of moderate problem behavior manifested by verbal abusiveness, physical abusiveness, or socially inappropriate/disruptive behavior.

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

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:

Please see d.

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:

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:

Case managers/early interventionists must have at least a Bachelor's degree in Social Work or a related field from an accredited college or university, or hold a Bachelor's degree in an unrelated field from an accredited college or university along with at least one (1) year of experience with the target population.

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):*

DDSN's case management system tracks due dates for reevaluations and alerts case managers and/or their supervisors in advance. If a LOC determination is not executed on time, FFP is recouped from DDSN for waiver services billed during the period of time for which the LOC was out of date.

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/or electronically retrievable documentation of all evaluations and reevaluations are maintained in DHHS case management systems and DDSN case management systems/files (or those of DDSN's sub-contractors).

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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:
Proportion of new enrollees whose level of care (LOC) is dated less than 30 days prior to waiver enrollment N = The number of LOC evaluations within the defined time period that are dated less than 30 days prior to waiver enrollment / D = The total number of LOC determinations that are completed in the defined time period

Data Source (Select one):
Other
If 'Other' is selected, specify:
DHHS 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:
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 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:
Adverse level of care determinations approved by DHHS QIO contractor N = number of adverse level of care determinations approved / 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:

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:
Proportion of LOC determinations conducted using the appropriate criteria and instrument N = the number of HASCI Waiver LOC determinations conducted using the appropriate criteria and instrument / D = the total number of HASCI Waiver LOC determinations reviewed

Data Source (Select one):
Other
If 'Other' is selected, specify:
DDSN QIO Reviews

Responsible Party for data		**Sampling Approach** *(check each that applies):*

collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(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 for each provider based on past performance. Reports are available within 30 days of the review.	

Data Source (Select one):
Other
If 'Other' is selected, specify:
DHHS QIO 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: DHHS QIO Contractor	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☑ **Other** Specify: Sampling is determined by nature of 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 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. DDSN contracted with a PhD Bio-statistician from the University of South Carolina to assist with the development of a sampling strategy for quality assurance reviews that meet CMS requirements. The number and type of individual waiver files included in each review were increased on July 1, 2012 after discussions with DHHS to further ensure adequate sample sizes across all waivers. The table below summarizes the sampling strategy. Using this strategy delivers results or point estimates with a 95% confidence interval no larger than plus or minus five percent for all DDSN-operated waivers.

	Group Size	Sample Size Per Provider	Proportion Meeting Tolerance*
ID/RD Waiver	>5500	5%	0.70-0.99
HASCI Waiver	+/- 650	22%	0.90-0.99
Community Support Waiver	>2000	10%	0.85-0.99

*The proportion meeting tolerance refers to the acceptable confidence intervals for the proportion estimates. For instance, the ID/RD Waiver meets acceptable confidence intervals for a proportion estimate between 70% and

99%.

References
1. Fleiss, J. L., Levin, B., Paik, M.C. 2003. 'Statistical Methods for Rates and Proportions.' Third Edition. John Wiley & Sons. New York.
2. Newcombe, R. G. 1998. 'Two-Sided Confidence Intervals for the Single Proportion: Comparison of Seven Methods.' Statistics in Medicine, 17, pp. 857-872.

QIO review sample sizes vary by provider size according the following table:

Provider Size	Beneficiaries Served	Sample Size
Very Large	700+	7% Up To 45
Large	150-699	8%
Medium	50-149	12
Small	0-49	7

An automated sample generating process has been developed for DDSN's Consumer Data Support System (CDSS). The process ensures appropriate numbers are selected within each category, appropriate randomization takes place, and deterministic sorts occur for a provider review. Sub-criteria, including a sample of individual residential and day service types are also included within this process. The review sample also includes an equal number of alternate names to be used, if needed.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
DHHS produces reports of findings based on reviews. These reports are shared with DDSN so they may develop and implement corrective action plans as appropriate. Corrective actions may include training, policy revisions and/or financial adjustments for Federal Financial Participation.

DDSN's QIO produces reports of findings based on provider reviews which are shared with DDSN and the providers. The providers are then required to develop and implement corrective action plans as appropriate. DDSN's QIO then conducts follow-up reviews to ensure corrective actions have been implemented. If needed, technical assistance is provided to providers by DDSN operations staff. Documentation of DDSN QIO reviews, provider corrective action plans, DDSN QIO follow-up reviews and technical assistance provided are available to DHHS through a portal or by other means.

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

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

c. Timelines
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).

   Care options are discussed with potentially eligible individuals (or their legal representatives) during the assessment and subsequent visits. The participant documents his/her preferred location for service delivery on a Freedom of Choice (FOC) Form provided by the case manager. The participant's choice remains in effect until the participant changes his/her mind. If the participant lacks the ability, his/her legal representatives may sign the Freedom of Choice Form.

   The FOC Form does not include language about the services available under the waiver. That information is on a waiver information sheet given to every applicant.

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):
Providers enrolling directly with DHHS acknowledge their obligation to comply with Title VI requirements as part of the South Carolina Medicaid provider enrollment process. Those wishing to report issues follow the relevant DHHS complaint process.

DDSN requires that each DSN Board/provider agency be in compliance with Title VI and establish a grievance procedure to assure that everyone is given a fair and timely review of all complaints alleging discrimination. All DDSN contracts with DSN Boards/provider agencies contain an “assurance of compliance” statement. DSN Boards/provider agencies must identify a compliance coordinator who is documented on every participant's annual plan. Compliance coordinators are responsible for assuring compliance and access to services by persons with limited English proficiency. The compliance coordinator maintains records documenting complaints filed and actions taken to bring resolution to the complaints. A DDSN state compliance coordinator is responsible for monitoring the compliance process. The DDSN state compliance coordinator assists the DSN Board/provider agency with identifying resources when necessary. The DDSN state compliance coordinator notifies DHHS when discrimination complaints are filed.

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	Attendant Care/Personal Assistance Services		
Statutory Service	Career Preparation Services		
Statutory Service	Day Activity		
Statutory Service	Residential Habilitation		
Statutory Service	Respite Care Services		
Statutory Service	Waiver Case Management (WCM)		
Extended State Plan Service	Incontinence Supplies		
Extended State Plan Service	Occupational Therapy		
Extended State Plan Service	Physical Therapy		
Extended State Plan Service	Speech and Hearing Services		
Other Service	Behavioral Support Services		
Other Service	Employment Services		
Other Service	Environmental Modifications		
Other Service	Health Education for Participant-Directed Care		
Other Service	Medicaid Waiver Nursing		
Other Service	Peer Guidance for Participant-Directed Care		
Other Service	Personal Emergency Response Systems		
Other Service	Pest Control Bed Bugs		
Other Service	Pest Control Treatment		
Other Service	Private Vehicle Assessment/Consultation		
Other Service	Private Vehicle Modifications		
Other Service	Psychological Services		
Other Service	Supplies, Equipment and Assistive Technology Assessment/Consultation		
Other Service	Supplies, Equipment and Assistive Technology		

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):

Attendant Care/Personal Assistance 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:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Attendant Care/Personal Assistance (AC/PA) are supports for personal care and activities of daily living specific to the assessed needs of a medically stable HASCI Waiver participant with physical and/or cognitive impairments. Supports may include direct care, hands-on assistance, direction and/or cueing, supervision, and nursing to the extent permitted by State law. The service may include housekeeping activities incidental to care or essential to the health, safety, and welfare of the participant, not other occupants of the participant's home.

AC/PA may be provided in the participant's home and/or other community settings only if attendant care or personal assistance is not already available in such settings. Supports provided during community access activities must directly relate to the participant's need for care and/or supervision.

Participants or the Responsible Party are offered the option to choose Self-Directed Attendant Care for all or part of their authorized Attendant Care/Personal Assistance. Supervision may be performed directly by the participant or a responsible party, when the participant or responsible party has been trained to perform this function, and when safety and efficacy of supervision provided by the participant or responsible party has been certified by a licensed nurse or otherwise as provided in State law. Certification must be based on direct observation of the participant or responsible party and the specific attendant care/personal assistance provider(s) during actual provision of care. Documentation of this certification will be maintained in the participant's Support Plan.

Transportation may be provided as a component of AC/PA when necessary for provision of personal care or performance of daily living activities. Cost of incidental transportation is included in the rate paid to the provider.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
The limit for AC/PA is 49 hours per week, *with no daily cap.

If a HASCI Waiver participant receives Medicaid Waiver Nursing (MWN) in addition to AC/PA, the total hours for the combination of MWN and AC/PA are limited to 10 hours per day or 70 hours per week. MWN limits apply (LPN: 60 hours per week; RN: 45 hours per week; combination LPN and RN: higher equivalent cost of 60 hours per week LPN or 45 hours per week RN).

The participant may use authorized hours flexibly during the week to best blend with the availability of other resources and natural supports. Unused hours in a particular week do not transfer to later weeks.

The intensity and frequency of supervision of AC/PA personnel are specified in the participant's Support Plan.
• For agency providers enrolled with DHHS, nursing supervision requirements are determined by DHHS (as necessary, but minimum every 4 months; supervision must be by a licensed RN or by a licensed LPN who is supervised by a licensed RN)
• For DSN Board or other DDSN-contracted agencies, supervision requirements are the same as for providers enrolled with DHHS (as necessary, but minimum every 4 months; supervision must be by a licensed RN or by a licensed LPN who is supervised by a licensed RN)
• For Self-Directed Attendant Care, ongoing supervision is the responsibility of the participant or Responsible Party. The participant or responsible party is trained to perform this function, and when safety and efficacy of supervision provided by the participant or responsible party has been certified by a licensed nurse or otherwise as provided in State law. Certification must be based on direct observation of the participant or responsible party and the specific attendant care/personal assistance provider(s) during actual provision of care. Documentation of this certification will be maintained in the participant's Support Plan.

*The limits may be exceeded if applying the limits would create a substantial risk that the individual would no longer be able to live in the community, but would, because of the limit in services, have to be institutionalized.

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

- [x] **Participant-directed as specified in Appendix E**
- [x] **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
Agency	DSN Board/contracted providers
Individual	Independent attendant care providers
Agency	Attendant Care Provider Agencies

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Attendant Care/Personal Assistance Services

Provider Category:
Agency
Provider Type:
DSN Board/contracted providers
Provider Qualifications
License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
DDSN Home Supports Caregiver Policy, Pre-service Training Requirements and Orientation (567- 01-DD) which lists requirements to include the outline of minimum requirements for the curriculum for HASCI Waiver caregivers.

DSN Boards are single or multiple county entities authorized in state statute to provide services at the local level under contract with DDSN. They may provide all DDSN-funded services for which they meet the relevant federal (including Medicaid), state, and DDSN requirements. Through a “Qualified Provider” solicitation process, DDSN also contracts with private organizations and individuals for specific DDSN-funded services for which they meet the relevant federal (including Medicaid), state, and DDSN requirements. This allows HASCI Waiver participants to have options for choosing providers.

For Attendant Care/Personal Assistance, a DSN Board or qualified provider is required for ensuring all AC/PA personnel meet minimum qualifications. SCDDSN's Home Supports Caregiver Certification must be completed for all AC/PA personnel. The DSN Board or qualified provider is responsible for ensuring that supervision of AC/PA personnel is provided by a nurse licensed in the state and according to SCDHHS standards for Attendant Care Services. The DSN Board or qualified provider is responsible for ensuring that any specific skilled nursing procedures performed by AC/PA personnel are formally delegated by a licensed Registered Nurse.

Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Disabilities and Special Needs
Frequency of Verification:
Upon enrollment

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Attendant Care/Personal Assistance Services

Provider Category:
Individual

Provider Type:
Independent attendant care providers

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
DDSN Home Supports Caregiver Policy, Pre-service Training Requirements and Orientation (567-01-DD) which lists requirements to include the outline of minimum requirements for the curriculum for HASCI Waiver caregivers

Verification of Provider Qualifications

Entity Responsible for Verification:
SCDDSN/UAP

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: Attendant Care/Personal Assistance Services

Provider Category:
Agency

Provider Type:
Attendant Care Provider Agencies

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
Contract Scope of Services

Verification of Provider Qualifications

Entity Responsible for Verification:
DHHS

Frequency of Verification:
Annually/Biannually

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:
Prevocational Services

Alternate Service Title (if any):
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:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Career Preparation assists a HASCI waiver participant for paid or unpaid employment by exposure to various careers and teaching such concepts as attendance, task completion, problem solving, safety, self-determination, and self-advocacy. It focuses on general employment-related knowledge, skills, and behavior, but not on specific job tasks. Services are reflected in the participant's service plan and are directed to habilitative rather than explicit employment objectives. Services will be provided in facilities licensed by the state.

Community activities that originate from a facility licensed by the state will be provided and billed as Career Preparation. On site attendance at the licensed facility is not required to receive services that originate from the facility.

Transportation will be provided from the participant's residence to the site of Career Preparation, or between Career Preparation sites. 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	DSN Board/contracted providers

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Career Preparation Services

Provider Category:
Agency

Provider Type:
DSN Board/contracted providers

Provider Qualifications

License *(specify):*
Section 44-20-10 et. Seq., Section 44-21-10 et. Seq., 40-120-170 thru 44-10-100 (Supp. 1995), Reg. #61-103

Certificate *(specify):*

Other Standard *(specify):*
For Career Preparation, a DSN Board or other contracted provider must operate a facility or program licensed by DDSN or its contracted QIO under SCDDSN Licensing Day Facility Standards. The DSN Board or qualified provider must comply with SCDDSN Day Services Standards and Career Preparation Services Standards.

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Disabilities and Special Needs

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:
Statutory Service

Service:
Day Habilitation

Alternate Service Title (if any):
Day Activity

HCBS Taxonomy:

Category 1: 04 Day Services

Sub-Category 1: 04020 day habilitation

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Day Activity assists a HASCI Waiver participant to acquire, retain, or improve in self-help, adaptive, and socialization skills, as well as community inclusion. It focuses on enabling the participant to attain or maintain maximum functional levels. The service is provided in or originates from a licensed, non-residential setting.

Transportation may be provided between the participant's place of residence and the site of Day Activity, or between Day Activity service sites. The cost of this transportation is included in the rate paid to 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**
- [x] **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
Agency	DSN Board/contracted providers

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Day Activity

Provider Category:
Agency

Provider Type:
DSN Board/contracted providers
Provider Qualifications
License *(specify):*
Section 44-20-10 et. Seq., Section 44-21-10 et. Seq., 40-120-170 thru 44-10-100 (Supp. 1995), Reg. #61-103
Certificate *(specify):*

Other Standard *(specify):*
For Day Activity, a DSN Board or other contracted provider must operate a facility or program licensed by DDSN or its contracted QIO under SCDDSN Licensing Day Facility Standards. The DSN Board or qualified provider must comply with SCDDSN Day Services Standards and Day Activity Services Standards.
Verification of Provider Qualifications
Entity Responsible for Verification:
Contracted with Department of Disabilities and Special Needs
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:
Statutory Service
Service:
Residential Habilitation
Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
02 Round-the-Clock Services	02011 group living, residential habilitation

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Category 4:	Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**

- ○ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Residential Habilitation means personal care, assistance with activities of daily living, to include community activities, supervision, behavior supports, and skills training provided to a HASCI Waiver participant through a licensed residential program. Individually tailored supports and training assist the participant to reside in the most integrated setting appropriate to his or her needs. Supports may include direct care, nursing to the extent permitted by State law, hands-on assistance, direction and/or cueing, and supervision. Training is focused on acquisition, retention, or improvement in skills for living in the community with maximum independence. Supports will also include social and leisure activities and community inclusion opportunities, as well as employment considerations.

Residential Habilitation funded by the HASCI Waiver must be provided within a residential facility or program contracted by DDSN. These include:

• Licensed Community Training Home I or II (CTH-I or CTH-II)
• Licensed Supervised Living Program I or II (SLP-I or SLP-II)
• Licensed Community Residential Care Facility (CRCF)

Payment for Residential Services does not include the cost of room and board or building maintenance, upkeep, and improvement, other than costs for modifications or adaptation required to assure the health and safety of residents or meet requirements of the applicable life safety code.

Payment for Residential Services will not be made for activities or supervision for which a payment is made by a source other than Medicaid.
Payment for Residential Services will not be made, directly or indirectly, to members of the participant's immediate family.

Transportation may be provided between the participant's place of residence and other locations as a component of Residential Services. The cost of this transportation is included in the rate paid to the residential 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	DSN Board/contracted providers

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Residential Habilitation

Provider Category:
Agency
Provider Type:

DSN Board/contracted providers

Provider Qualifications

License *(specify):*

Section 44-20-10 et. Seq., Section 44-21-10 et. Seq., 40-120-170 thru 44-10-100 (Supp. 1995), Reg. #61-103

Certificate *(specify):*

Other Standard *(specify):*

Contracted with Department of Disabilities and Special Needs.

The DSN Board or qualified provider must operate residences or programs licensed by SCDDSN or its contracted QIO under SCDDSN Residential Licensing Standards.

The DSN Board or qualified provider must comply with SCDDSN Residential Habilitation Standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Disabilities and Special Needs

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:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

Respite Care Services

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

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

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

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

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

○ **Service is included in approved waiver. There is no change in service specifications.**

- (●) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Respite Care is assistance and supervision provided to a HASCI Waiver participant due to a short-term absence of or need for relief by those normally providing unpaid care. It can be provided on a periodic and/or emergency basis to relieve one or more unpaid caregivers. The service may include hands-on assistance or direction/cueing for personal care and/or general supervision to assure safety. It may include skilled nursing procedures only if these are specifically delegated by a licensed nurse or as otherwise permitted by State law.

Respite Care may be provided in a variety of community or institutional settings. Federal Financial Participation (FFP) will not be claimed for cost of room and board except if Respite Care is provided in a facility approved by the State that is not a private residence.

The State has identified the following non-institutional respite care locations for HASCI participants, in which, respite care can be provided on an hourly basis. The following include the non-institutional locations:
• Participant's home or place of residence, or other residence selected by the participant/representative
• Group Home
o Licensed residence (CTH-I or CTH-II) o Licensed foster care home
o Licensed Community Residential Care Facility (CRCF)

Institutional Respite Care on a daily basis may be provided in the following locations:
• Medicaid-certified hospital
• Medicaid-certified nursing facility (NF)
• Medicaid-certified Intermediate Care Facility for the Intellectually Disabled (ICF-ID); this may be at a Regional Center or a community ICF-ID.

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**
- [x] **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
Agency	Respite Provider Agencies
Agency	Medicaid Certified Nursing Facility
Agency	Hospital
Agency	Community Residential Care Facility (CRCF)
Agency	Medicaid certified ICF/ID
Agency	DDSN/DSN Board/Contracted providers
Agency	Foster Home

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:
Respite Provider Agencies
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
MOA and Service Contract with DHHS
Verification of Provider Qualifications
Entity Responsible for Verification:
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 Nursing Facility
Provider Qualifications
License *(specify):*
SC Code Ann. §44-7-250 thru 44-7-260 Reg. 61-17, Equivalent for NC & GA
Certificate *(specify):*

Other Standard *(specify):*
Contracted with DHHS for Institutional Respite
Verification of Provider Qualifications
Entity Responsible for Verification:
DHEC and 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:
Hospital
Provider Qualifications
License *(specify):*

SC Code, Sec. 44-7-260 Reg. #61-16, Equivalent for NC & GA
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
DHEC and DHHS
Frequency of Verification:
Upon Enrollment and CMS Revalidation Requirements

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:
Community Residential Care Facility (CRCF)
Provider Qualifications
License *(specify):*
SC Code, Sec. 44-7-260 Reg. #61-84, Equivalent for NC & GA
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
DHEC and 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/ID
Provider Qualifications
License *(specify):*
SC Code Ann. §44-7-250 thru 44-7-260 Reg. #61-13
Certificate *(specify):*

Other Standard *(specify):*

Contracted with DDSN/Respite care standards policy, Pre-service Training Requirements and Orientation (567-01-DD) which lists requirements to include the outline of minimum requirements for the curriculum for HASCI Waiver caregivers

Verification of Provider Qualifications

Entity Responsible for Verification:

DDSN; DHEC

Frequency of Verification:

Upon Enrollment; 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/DSN Board/Contracted providers

Provider Qualifications

License *(specify):*

SC Code Ann. §44-20-10 thru 44-20-5000 (Supp. 2008); §44-20-710 (Supp. 2008)

Certificate *(specify):*

Other Standard *(specify):*

DDSN Respite Care Standards policy, Pre-service Training Requirements and Orientation (567-01-DD) which lists requirements to include the outline of minimum requirements for the curriculum for HASCI Waiver caregivers.

The DSN Board or qualified provider must comply with SCDDSN Respite Program Standards and must ensure that Respite Care workers meet the stipulated minimum qualifications.

The DSN Board or qualified provider must comply with SCDDSN Directives 567-01-DD, Employee Orientation, Pre-Service and Annual Training Requirements and 735-02-DD, Relatives/Family Members Serving as Paid Caregivers of Respite Services.

If Respite Care will be provided in a participant's home or other private residence, the DSN Board or qualified provide must certify Respite Care workers using SCDDSN's Home Supports Caregiver Certification.

Verification of Provider Qualifications

Entity Responsible for Verification:

DDSN

Frequency of Verification:

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

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:

Foster Home

Provider Qualifications

License *(specify)*:

Yes, SC Code; Sec. 20-7-2250

Certificate *(specify)*:

Other Standard *(specify)*:

Verification of Provider Qualifications

Entity Responsible for Verification:

SC Department of Social Services (DSS)

Frequency of Verification:

Upon enrollment;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:

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:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope)*:
Services that assist participants in gaining access to needed waiver and other State plan services, as well as medical, social, education and other services, 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 service plans as specified in waiver policy. This includes the ongoing monitoring for 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, as specified in waiver policy.

For waiver participants utilizing participant/representative directed-care waiver services, waiver case managers must provide supports to participants/representatives about any options and/or obligations. Waiver case managers are responsible for documenting the choice between institutional care or home and community-based services using the approved Freedom of Choice document.

Pre-enrollment activities that directly facilitate waiver enrollment for individuals leaving the facility can be conducted for 120 days prior to enrollment as part of waiver case management. Billing for these activities may not occur until after the participant is enrolled.

Waiver case managers must make monthly contacts to the participant/family for the purpose of monitoring the Individual Plan of Service, services and participant health and welfare. Waiver case managers must perform a minimum of four (4) quarterly face-to-face visits with the participant/family each calendar year for the purpose of monitoring the Individual Plan of Service, services, and the participant's health and welfare. Two (2) of the four quarterly face-to-face visits each year must be in the home/natural environment. Monthly contacts to monitor the Plan, services and health and welfare are not required in the same months when the waiver case manager makes a quarterly visit with the participant/family.
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**
- [x] **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
Agency	Waiver Case Manager 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 Manager Provider
Provider Qualifications
License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
All waiver case managers must have the following education and/or experience:
-Bachelor's degree or higher in a Health or Human Services field plus one year of experience with services to people with disabilities and special needs and/or with case management services;
-OR a Bachelor's degree or higher in a field unrelated to the Health or Human Services field plus two years of experience with services to people with disabilities and special needs and/or case management services;
-OR a Registered Nurse licensed in the State of South Carolina plus one year of experience with services to people with disabilities and special needs and/or with case management services.

All degrees must be from a post-secondary education institution recognized by the U.S. Department of Education and/or the Council for Higher Education (CHEA). Note: Degrees from regionally-accredited post-secondary education institutions are acceptable as determined by the SC Department of Education in the most current version of its Educator Certification Manual.

All waiver case managers must have a valid driver's license; must be tested for TB annually and if necessary complete the required treatment in order to serve waiver participants; and successfully pass a criminal background check with South Carolina Law Enforcement (SLED); and at a minimum be screened against the following: 1) Child Abuse and Neglect Central Registry and 2) Sexual Offender Registry.

Verification of Provider Qualifications

Entity Responsible for Verification:
Qualified waiver case managers must meet these standards prior to employment. The provider agency that employs the case manager is responsible for ensuring case manager qualifications. The waiver case management agency enrolls/contracts with SCDHHS.

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:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Incontinence Supplies are standard diapers, briefs (protective underwear), under pads, liners, wipes, and gloves needed by a HASCI Waiver participant age 2 years and older who is incontinent of bladder and/or bowel according to medical criteria. It is an Extended State Plan Service to allow additional items above the limits covered by the Medicaid State Plan under Home Health services.

All medically necessary Specialized Medical Supplies and Therapy Services for children under age 21 are covered in the state plan pursuant to the EPSDT benefit.
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's record for adults age 21 and older, in addition to State Plan Services. The State has the following limits:
-up to 192 diapers per month (2 cases)
-up to 160 briefs per month (2 cases)
-up to two (2) cases of under pads per month
-up to 260 liners per month (2 cases)
-up to 560 wipes per month (8 boxes)
-up to four (4) boxes of gloves per month

*The limits may be exceeded if applying the limits would create a substantial risk that the individual would no longer be able to live in the community, but would, because of the limit in services, have to be institutionalized.

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):*

Certificate *(specify):*

Other Standard *(specify):*
Enrolled with SCDHHS to provide incontinence supplies

Verification of Provider Qualifications

Entity Responsible for Verification:
SCDHHS

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:
Extended State Plan Service

Service Title:
Occupational Therapy

HCBS Taxonomy:

Category 1:	Sub-Category 1:
11 Other Health and Therapeutic Services	080 occupational therapy

Category 2:	Sub-Category 2:
11 Other Health and Therapeutic Services	020 health assessment

Category 3:	Sub-Category 3:

Category 4:	Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Services that are provided when occupational therapy services are exhausted under the approved State plan limits. The scope and nature of these services do not differ from occupational therapy furnished under the State plan. The provider qualifications specified in the State plan apply.

All medically necessary Specialized Medical Supplies and Therapy Services for children under age 21 are covered in the state plan pursuant to the EPSDT benefit.

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**
- [x] **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	Occupational Therapists
Agency	Occupational Therapy Groups

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Occupational Therapy

Provider Category:
Individual

Provider Type:
Occupational Therapists

Provider Qualifications

License *(specify)*:
Chapter 36 section 40-35-5 et. Seq. SC code of laws. Equivalent NC and GA.

Certificate *(specify)*:

Other Standard *(specify)*:

Verification of Provider Qualifications

Entity Responsible for Verification:
Labor, Licensing and Regulation; Medicaid agency

Frequency of Verification:
Upon Enrollment

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Occupational Therapy

Provider Category:
Agency

Provider Type:

Occupational Therapy Groups
Provider Qualifications
License *(specify)*:
Chapter 36 section 40-35-5 et. Seq. SC code of laws. Equivalent NC and GA.
Certificate *(specify)*:

Other Standard *(specify)*:

Verification of Provider Qualifications
Entity Responsible for Verification:
Labor, Licensing and Regulation; Medicaid Agency
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:
Extended State Plan Service
Service Title:
Physical Therapy

HCBS Taxonomy:

Category 1:	Sub-Category 1:
11 Other Health and Therapeutic Services	090 physical therapy
Category 2:	**Sub-Category 2:**
11 Other Health and Therapeutic Services	020 health assessment
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope)*:
Services that are provided when physical therapy services are exhausted under the approved State plan limits. The scope and nature of these services do not differ from physical therapy furnished under the State plan. The provider

qualifications specified in the State plan apply.

All medically necessary Specialized Medical Supplies and Therapy Services for children under age 21 are covered in the state plan pursuant to the EPSDT benefit.

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**
- [x] **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	Physical Therapists
Agency	Physical Therapy Groups

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Physical Therapy

Provider Category:
Individual

Provider Type:
Physical Therapists

Provider Qualifications

License *(specify)*:
Chapter 45 section 40-45-5 et. Seq. SC code of laws. Equivalent NC and GA.

Certificate *(specify)*:

Other Standard *(specify)*:

Verification of Provider Qualifications

Entity Responsible for Verification:
Labor, Licensing and Regulation; Medicaid Agency

Frequency of Verification:
Upon Enrollment

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Physical Therapy

Provider Category:

Agency

Provider Type:
Physical Therapy Groups
Provider Qualifications
License *(specify):*
Chapter 45 section 40-45-5 et. Seq. SC code of laws. Equivalent NC and GA.
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Labor, Licensing and Regulation; Medicaid Agency
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:
Extended State Plan Service
Service Title:
Speech and Hearing Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
11 Other Health and Therapeutic Services	100 speech, hearing, and language therapy

Category 2:	Sub-Category 2:
11 Other Health and Therapeutic Services	020 health assessment

Category 3:	Sub-Category 3:

Category 4:	Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Services that are provided when speech, hearing and language services are exhausted under the approved State plan limits. The scope and nature of these services do not differ from speech, hearing and language services furnished under the State plan. The provider qualifications specified in the State plan apply.

All medically necessary Specialized Medical Supplies and Therapy Services for children under age 21 are covered in the state plan pursuant to the EPSDT benefit.
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**
- [x] **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	Speech Pathologists
Individual	Audiologists
Agency	Audiology Groups
Agency	Speech Therapy Group
Individual	Speech Therapists
Agency	Speech Pathology Groups

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Speech and Hearing Services

Provider Category:
Individual
Provider Type:
Speech Pathologists
Provider Qualifications
License *(specify):*
Chapter 67 section 40-67-10 & 40-67-60 et. Seq. SC code of laws. Equivalent NC and GA
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Labor, Licensing and Regulation; Medicaid agency
Frequency of Verification:
Upon Enrollment

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Speech and Hearing Services

Provider Category:
Individual
Provider Type:
Audiologists
Provider Qualifications
License *(specify):*
Chapter 67 section 40-67-10 & 40-67-60 et. Seq. SC code of laws. Equivalent NC and GA.
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Labor, Licensing and Regulation; Medicaid Agency
Frequency of Verification:
Upon Enrollment

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Speech and Hearing Services

Provider Category:
Agency
Provider Type:
Audiology Groups
Provider Qualifications
License *(specify):*
Chapter 67 section 40-67-10 & 40-67-60 et. Seq. SC code of laws. Equivalent NC and GA.
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Labor, Licensing, and Regulation; Medicaid agency
Frequency of Verification:
Upon Enrollment

Appendix C: Participant Services

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

Service Type: Extended State Plan Service

Service Name: Speech and Hearing Services

Provider Category:
Agency
Provider Type:
Speech Therapy Group
Provider Qualifications
License *(specify)*:
Chapter 67 section 40-67-10 & 40-67-60 et. Seq. SC code of laws. Equivalent NC and GA
Certificate *(specify)*:

Other Standard *(specify)*:

Verification of Provider Qualifications
Entity Responsible for Verification:
Labor, Licensing, and Regulation; Medicaid agency
Frequency of Verification:
Upon enrollment

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Speech and Hearing Services

Provider Category:
Individual
Provider Type:
Speech Therapists
Provider Qualifications
License *(specify)*:
Chapter 67 section 40-67-10 & 40-67-60 et. Seq. SC code of laws. Equivalent NC and GA
Certificate *(specify)*:

Other Standard *(specify)*:

Verification of Provider Qualifications
Entity Responsible for Verification:
Labor, Licensing and Regulation; Medicaid agency
Frequency of Verification:
Upon Enrollment

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Speech and Hearing Services

Provider Category:
Agency
Provider Type:
Speech Pathology Groups

Provider Qualifications

License *(specify):*

Chapter 67 section 40-67-10 & 40-67-60 et. Seq. SC code of laws. Equivalent NC and GA

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Labor, Licensing, and Regulation; Medicaid agency

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:

Behavioral Support Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
10 Other Mental Health and Behavioral Services	10090 other mental health and behavioral services

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Category 4:	Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Behavior Support addresses behavioral challenges experienced by a HASCI Waiver participant by using evidence based, validated practices to identify causes and appropriate interventions that prevent or reduce occurrence. Behavior Support includes functional behavior assessments and analyses; development of behavioral support plans; implementing interventions designated in behavior support plans; training key persons to implement interventions designated in behavioral support plans; monitoring effectiveness of behavioral support plans and modifying as necessary; and educating family, friends, or service providers concerning strategies and techniques to assist the participant in modifying inappropriate behaviors, including the necessary education for the waiver participant to do this independently when possible.

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

For a HASCI Waiver participant who receives Residential Services, behavior support is a component of Residential Services and included in the rate paid to the residential provider.

If the participant needs Behavior Support, the residential provider must directly provide or obtain it.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **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: Behavioral Support Services

Provider Category:

Individual

Provider Type:

Behavior Support Provider

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:

A provider must follow the DDSN standards and qualifications. The DSN Board or qualified provider must comply with SCDDSN Behavior Support Standards. A DSN Board or qualified provider of Residential Habilitation that currently serves a specific HASCI Waiver participant in need of Behavior Support must employ or contract with an individual enrolled with SCDHHS as a provider of Behavior Support Services.

Verification of Provider Qualifications

Entity Responsible for Verification:

Verified and approved by DDSN; 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:

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:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope)*:

Employment Services are provided in regular competitive employment settings such as factories, offices, stores, restaurants, etc. where people without disabilities are employed. Employment Services provides an intensive or ongoing supports so a HASCI waiver participant for whom competitive employment at or above the minimum wage, is unlikely can perform in a paid work setting. It may include assisting the participant to locate a job or to have a job developed specifically for him or her. The service may be provided in a variety of work settings, particularly sites where persons without disabilities are employed; such as an enclave or a mobile crew, or an individual job placement in the community.

Participants can choose from among these three services (Employment Services, Career Preparation, and Day Activity) in developing their service plans, but only one of them can be authorized at any given time. If a participant chooses to change the selected service, he or she can request to change his or her service plan.

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 Board/Contracted 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:
DDSN/DSN Board/Contracted Provider
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
DDSN employment services standards. The DSN Board or qualified provider must operate a facility or program licensed by SCDDSN or its contracted QIO under SCDDSN Licensing Day Facility Standards. The DSN Board or qualified provider must comply with SCDDSN Day Services Standards and Employment 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:
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:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Environmental Modifications are physical adaptations to the home, required by the HASCI waiver participant's Support Plan, which are necessary to ensure the health, welfare and safety of the participant, or which enable the participant to function with greater independence in the home. The home must be a privately owned residence occupied by the participant. Modifications to publicly funded group homes or community residential facilities are not permitted. Such adaptations may include the installation of ramps and grab-bars, widening of doorways modification of bathroom or kitchen 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 participant, floor covering to facilitate wheelchair access, fencing necessary for a participant's safety.

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. Environmental modifications will not be approved solely for the needs or convenience of other occupants of the home or care providers. Modifications that add to the total square footage of the home are available only when this modification proves to be the most cost effective solution. All services shall be provided in accordance with applicable state and local building codes and shall be subject to the state procurement act.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Home Modifications are subject to the guidelines established by the SCDDSN Head and Spinal Cord Injury Division (Guidance in Waiver Manual) and must be within the limit of $20,000 per modification.

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

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

Provider Category	Provider Type Title
Individual	Licensed Contractors
Agency	DDSN/DSN Boards/Contracted Providers
Individual	Licensed Occupational and Physical Therapists
Individual	Vendors with a retail or wholesale business license contracted to provide services
Individual	Rehabilitation Engineering Technologists, Assistive Technology Practitioners and Assistive Technology Suppliers certified by the Rehabilitation Engineering Society of North America (RESNA)
Individual	Certified ADA Coordinators

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Modifications

Provider Category:
Individual
Provider Type:
Licensed Contractors
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: 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 must employ or contract with the following, but is responsible to verify and document licensure:

• 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

In addition to the above, 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 verify and document 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)

Verification of Provider Qualifications

Entity Responsible for Verification:
DDSN
Frequency of Verification:
Annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Modifications

Provider Category:
Individual
Provider Type:
Licensed Occupational and Physical Therapists
Provider Qualifications

License *(specify)*:
Chapter 36 section 40-35-5 et. Seq. SC code of laws. Equivalent NC and GA. Chapter 45 section 40-45-5 et. Seq. SC cod of laws. Equivalent NC and GA.
Certificate *(specify)*:

Other Standard *(specify)*:
Contracted with DDSN or Medicaid Agency

Verification of Provider Qualifications

Entity Responsible for Verification:
Labor, Licensing and Regulation; Medicaid Agency
Frequency of Verification:
Upon enrollment

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Modifications

Provider Category:
Individual
Provider Type:
Vendors with a retail or wholesale business license contracted to provide services

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Enrolled with DHHS/DDSN

Verification of Provider Qualifications

Entity Responsible for Verification:
DDSN

Frequency of Verification:
Upon Enrollment

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Modifications

Provider Category:
Individual

Provider Type:
Rehabilitation Engineering Technologists, Assistive Technology Practitioners and Assistive Technology Suppliers certified by the Rehabilitation Engineering Society of North America (RESNA)

Provider Qualifications

License *(specify):*

Certificate *(specify):*
Certified by the Rehabilitation Engineering Society of North America (RESNA)

Other Standard *(specify):*
Contracted with DDSN or Medicaid Agency

Verification of Provider Qualifications

Entity Responsible for Verification:
DDSN

Frequency of Verification:
Upon enrollment or service authorization

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Modifications

Provider Category:
Individual

Provider Type:
Certified ADA Coordinators

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certified ADA Coordinator
Other Standard *(specify):*
Enrolled with DHHS/DDSN
Verification of Provider Qualifications
Entity Responsible for Verification:
DDSN
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:
Health Education for Participant-Directed Care

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:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Health Education for Participant-Directed Care prepares capable individuals who desire to manage their own personal care or a family member or other responsible party who desires to manage the personal care of an individual not capable of self-management.
Health Education for Participant-Directed Care is instruction provided by a licensed registered nurse who are provided the "Key to Independence Manual" from the Shepherd Center in Atlanta, Georgia and/or other curricula approved by SCDDSN/DHHS in the provision of this service. The training provided by an RN will regard the

nature of specific medical conditions, the promotion of good health, and the prevention/monitoring of secondary medical conditions.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Ten units per calendar year.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **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
Agency	DSN Board/contracted providers

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Health Education for Participant-Directed Care

Provider Category:
Agency

Provider Type:
DSN Board/contracted providers

Provider Qualifications

License *(specify)*:
Yes, Section 44-20-10 et. Seq., Section 44-21-10 et. Seq., 40-120-170 thru 44-10-100 (Supp. 1995), Reg. #61-103

Certificate *(specify)*:

Other Standard *(specify)*:
The DSN Board or qualified provider must employ or contract with a licensed RN to perform this service and is responsible to verify the credentials of the RN.

The RN employed or contracted by the provider must:
• be licensed as a Registered Nurse by South Carolina Board of Nursing or the equivalent licensing body in North Carolina or Georgia
• use Key to Independence Manual from the Shepherd Center in Atlanta, Georgia and/or other curriculum approved by SCDDSN, as a guide in providing education on bladder and bowel care, skin care, respiratory care, sexuality, substance abuse issues, and monitoring of health status and medical conditions
• address the participant's specific medical conditions and functional limitations, promotion of good health, and prevention/monitoring of secondary medical conditions

Verification of Provider Qualifications

Entity Responsible for Verification:
Department of Disabilities and Special Needs

Frequency of Verification:
Upon enrollment or service authorization

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:

Medicaid Waiver Nursing

HCBS Taxonomy:

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

Category 2:	Sub-Category 2:
05 Nursing	05010 private duty nursing

Category 3:	Sub-Category 3:

Category 4:	Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope)*:

Medicaid Waiver Nursing (MWN) is nursing care provided to a HASCI Waiver participant age 21 years or older which is within the scope of the state's Nurse Practice Act and provided by a professional registered nurse (RN) or licensed practical nurse (LPN).

MWN is authorized based upon a physician's order that specifies the skilled care and type of nurse (RN/LPN) that is medically necessary. The amount of nursing initially authorized is determined through SCDDSN's centralized nursing review process and is re-determined at least annually or in other designated review period.

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

Medicaid Waiver Nursing is limited to either 60 hours per week of LPN or 45 hours per week of RN. If a combination of LPN and RN is used, the combined hours per week cannot exceed the equivalent cost of either 60 hours per week of LPN or 45 hours per week of RN. If HASCI Waiver Nursing is combined with Attendant Care/Personal Assistance Services, the combined services, whether routine or short term, shall not exceed 10 hours per day or 70 hours per week. Unused units in a particular week cannot be transferred to another week.

*The limits may be exceeded if applying the limits would create a substantial risk that the individual would no longer be able to live in the community, but would, because of the limit in services, have to be institutionalized.

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	Nursing Agencies
Individual	Registered Nurses

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Medicaid Waiver Nursing

Provider Category:
Agency
Provider Type:
Nursing Agencies
Provider Qualifications
License *(specify):*
Yes, Code of laws 40-33-10 et seq
Certificate *(specify):*
Other Standard *(specify):*
Contract Scope of services
Verification of Provider Qualifications
Entity Responsible for Verification:
Medicaid Agency
Frequency of Verification:
Upon Enrollment Annually/Biannually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Medicaid Waiver Nursing

Provider Category:
Individual
Provider Type:
Registered Nurses
Provider Qualifications
License *(specify):*
Yes, Code of laws 40-33-10 et seq
Certificate *(specify):*
Other Standard *(specify):*
Contract Scope of services
Verification of Provider Qualifications

Entity Responsible for Verification:
Medicaid Agency
Frequency of Verification:
Upon Enrollment Annually/Biannually

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:
Peer Guidance for Participant-Directed Care

HCBS Taxonomy:

Category 1:	Sub-Category 1:
10 Other Mental Health and Behavioral Services	10050 peer specialist

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Category 4:	Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Peer Guidance for Participant-Directed Care prepares and assists capable individuals who desire to manage their own personal care. It is information, advice, and encouragement provided by a trained Peer Mentor to help a participant with participant in recruiting, training, and supervising primary and back-up attendant care/personal assistance providers and self advocacy.
The Peer Mentor is a participant who successfully lives in the community with a high degree of independence and who directs his or her own personal care needs. The Peer Mentor serves as a role model and shares information and advice from his or her experiences and helps promote independence.

The Peer Mentor will use the “Peer Support Curriculum” from the Shepherd Center in Atlanta, Georgia or other curriculum approved by SCDDSN.
Service Unit.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
12 units per calendar year.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **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
Agency	DSN Board/contracted providers

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Peer Guidance for Participant-Directed Care

Provider Category:
Agency
Provider Type:
DSN Board/contracted providers
Provider Qualifications
License *(specify)*:
Yes, Section 44-20-10 et. Seq., Section 44-21-10 et. Seq., 40-120-170 thru 44-10-100 (Supp. 1995), Reg. #61-103
Certificate *(specify)*:

Other Standard *(specify)*:
Contracted with SCDDSN, Peer Mentors must be registered with and trained by the SCDDSN approved providers.
The DSN Board or qualified provider must employ or contract with a Peer Mentor who meets the following minimum qualifications and is responsible to verify these qualifications are met:
• The individual is a HASCI Waiver participant and lives successfully in the community

• Be at least 18 years old, with maturity and ability to deal effectively with the job
• Have a high degree of independence and direct his or her own personal care
• Able to communicate effectively
• Free from communicable diseases
• Provide a SLED check
• Be trained/approved by SCDDSN approved provider
• Use the Peer Support Curriculum from the Shepherd Center in Atlanta, Georgia and/or other curriculum approved by SCDDSN, as a guide in providing peer guidance to participants in the HASCI Waiver who desire to manage their own care

Verification of Provider Qualifications
Entity Responsible for Verification:
Department of Disabilities and Special Needs
Frequency of Verification:
Upon enrollment or service authorization

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

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:

Category 4:	Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope)*:

PERS is an electronic device which enables a HASCI Waiver participant at high risk of institutionalization to secure help in an emergency. PERS provides ongoing monitoring, as the system is connected to the participant's telephone and programmed to signal an emergency response center staffed by trained professionals. The participant may wear a "help" button that allows for mobility. PERS services are limited to those individuals who live alone, or who are alone for any part of the day or night, and who would otherwise require extensive routine 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**
- [x] **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
Agency	Personal Emergency Response providers

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Emergency Response Systems

Provider Category:
Agency

Provider Type:
Personal Emergency Response providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:
Medicaid Agency

Frequency of Verification:
Upon enrollment or service authorization

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:
Pest Control Bed Bugs

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:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ○ **Service is included in approved waiver. The service specifications have been modified.**
- ◉ **Service is not included in the approved waiver.**

Service Definition *(Scope)*:
Pest control bed bug services aid in maintaining an environment free of bed bugs and other potential disease carriers to enhance safety, sanitation, and cleanliness of the participant's home/or residence.

The Provider must obtain an authorization from their WCM to designate the amount, frequency and duration of service for participants.

All instructions on the authorization for service must be followed in order to be reimbursed for the pest control service. Pest control services for bed bugs must be completed by the provider within 14 days of acceptance of the WCM authorization for service.

For bed bugs all providers must go into the participant's home/or residence to inspect and treat the participant's home/or residence. A responsible adult who is eighteen years of age or older must be at the participant's home/or residence at the time of the treatment or the provider will need to reschedule for a time when the responsible adult who is eighteen years of age or older will be present at the participant's home/or residence.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Services are limited to one time per year.
This service does not apply to residential habilitation settings.

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	Licensed Business

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Pest Control Bed Bugs

Provider Category:
Agency
Provider Type:
Licensed Business
Provider Qualifications
License *(specify):*
South Carolina Business License
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
DHHS
Frequency of Verification:
Upon enrollment/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:
Pest Control Treatment

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:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

○ **Service is included in approved waiver. There is no change in service specifications.**

- ○ **Service is included in approved waiver. The service specifications have been modified.**
- ◉ **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Pest Control Treatment aids in maintaining an environment free of insects such as roaches and other potential disease carriers to enhance safety, sanitation, and cleanliness of the participant's home/or residence.

The Provider must obtain an authorization from their WCM to designate the amount, frequency and duration of service for participants.

Pest control authorizations are for a maximum of once every other month. The Provider will receive new authorizations only when there is a change to the authorized service amount, frequency or duration. All instructions on the authorization for service must be followed in order to be reimbursed for the pest control service. Pest control services must be completed by the provider within 14 days of acceptance of the WCM authorization for service.

Pest Control treatments need to include both in-home and exterior treatment. All providers must go into the participant's home/or residence to inspect and treat the home environment. A responsible adult who is eighteen years of age or older must be at the participant's home/or residence at the time of the treatment or the provider will need to reschedule for a time when the responsible adult who is eighteen years of age or older will be present at the participant's home/or residence.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Pest control treatment is limited to every other month. This service does not apply to residential habilitation settings.

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	Licensed Business

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Pest Control Treatment

Provider Category:
Agency
Provider Type:
Licensed Business
Provider Qualifications
License *(specify):*
South Carolina Business License
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
DHHS
Frequency of Verification:
Upon enrollment/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:
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:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ○ **Service is included in approved waiver. The service specifications have been modified.**
- ◉ **Service is not included in the approved waiver.**

Service Definition *(Scope):*
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 this barrier.

Private vehicle assessment/consultation may include the specific modifications/equipment needed, any follow-up inspection after modifications are completed, and training in use of 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 or 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 $600.00.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **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	OT, PT, Rehabilitation Engineering Technologists, Assistive Technology Practitioners, Assistive Technology Suppliers, Environmental Access/Consultants/contractors

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)*:
Environmental Assessments/Consultations can be completed by vendors who are contracted through the DSN Board to provide the service.
Verification of Provider Qualifications
Entity Responsible for Verification:
DDSN
Frequency of Verification:
Annually

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:
OT, PT, Rehabilitation Engineering Technologists, Assistive Technology Practitioners, Assistive Technology Suppliers, Environmental Access/Consultants/contractors
Provider Qualifications
License *(specify):*
Licensed Medicaid enrolled Occupational (OT) or Physical Therapists (PT), and Rehabilitation Engineering Technologists (RET).
Certificate *(specify):*
Assistive Technology Practitioners (ATP) and Assistive Technology Suppliers (ATS) certified by the Rehabilitation Engineering Society of North American (RESNA), Medicaid enrolled Environmental Access/Consultants/contractors (EACC).
Other Standard *(specify):*
DHHS Medicaid 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:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Modifications to a privately owned vehicle to be driven by or routinely used to transport a HASCI Waiver participant. It may include any equipment necessary to make the vehicle accessible to the participant. Modifications of a vehicle owned by a publicly funded agency are not permitted. Modifications can include follow up inspections, training in use of equipment, repairs not covered by warranty, and replacement of parts or equipment. The approval process for private vehicle modifications is initiated based upon the needs specified in the participant's Support Plan and following confirmation of the availability of a privately owned vehicle to be driven by or routinely used to transport the participant. The approval process is the same for any private vehicle modification, regardless of ownership. Each request must receive prior approval following programmatic and fiscal review and shall be subject to the state procurement act. Programmatic approval alone may be given for emergency repair of equipment to ensure safety of the participant.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Private Vehicle Modifications are subject to the guidelines
established by the SCDDSN Head and Spinal Cord Injury Division (Guidance in Waiver Manual) and must be within the limit of $30,000 per vehicle.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **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
Agency	DDSN/DSN Board/contracted providers
Agency	DHHS Enrolled Providers

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 providers
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The DSN Board or qualified provider must employ or contract with the following, but is responsible to verify and document licensure:
• 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
In addition to the above, 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 verify and document 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)

Verification of Provider Qualifications

Entity Responsible for Verification:
DDSN

Frequency of Verification:
Annually

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: 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:

Psychological Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
10 Other Mental Health and Behavioral Services	10060 counseling

Category 2:	Sub-Category 2:
10 Other Mental Health and Behavioral Services	10010 mental health assessment

Category 3:	Sub-Category 3:

Category 4:	Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Psychological Services address the affective, cognitive, and substance abuse problems of a HASCI Waiver participant age 21 years or older. It includes psychiatric, psychological, and neuropsychological evaluation; development of treatment plans; individual/family counseling to address the participant's affective, cognitive, and substance abuse problems; cognitive rehabilitation therapy; and alcohol/substance abuse counseling. The service may include consultation with family members/others or service providers to assist implementing the participant's treatment plan and assist in goal-oriented counseling/therapy.

Psychological Services funded by the HASCI Waiver may be provided only if a participant is unable to access or has exhausted benefits under Rehabilitative Behavioral Health Services funded by Medicaid State Plan or needs services not available under Medicaid State Plan. Current Rehabilitative Behavioral Health Services do not include neuropsychological evaluation/treatment or cognitive rehabilitation therapy.

Psychological Services funded by the HASCI Waiver may be provided only if a participant is unable to access or has exhausted benefits under Rehabilitative Behavioral Health Services funded by Medicaid State Plan or needs services not available under Medicaid State Plan. Current Rehabilitative Behavioral Health Services do not include neuropsychological evaluation/treatment or cognitive rehabilitation therapy.

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**
- [x] **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	Psychological Service Provider
Agency	Psychological Service Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Psychological Services

Provider Category:
Individual

Provider Type:
Psychological Service Provider

Provider Qualifications

License *(specify):*
Code of Law of SC, 1976 amended, 40-55-20 et. seq. 40-75-5 et. seq.

Certificate *(specify):*

Other Standard *(specify):*
Enrolled by DHHS.

A DSN Board or qualified provider of Residential Habilitation that currently serves a specific HASCI Waiver participant in need of Psychological Services must employ or contract with an individual enrolled with SCDHHS as a provider of Psychological Services or must employ or contract with a professional enrolled with SCDHHS as a Licensed Independent Practitioner of Rehabilitative Services (LIPS) provider.
The DSN Board or qualified provider must comply with SCDDSN Psychological Services Standards.

Verification of Provider Qualifications

Entity Responsible for Verification:
DDSN/DHHS

Frequency of Verification:
Upon enrollment and verification of continuing education every two years.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Psychological Services

Provider Category:
Agency

Provider Type:
Psychological Service Provider

Provider Qualifications

License *(specify):*
Code of Law of SC, 1976 amended; 40-55-20 et seq., 40-75-5 et seq.

Certificate *(specify):*

Other Standard *(specify):*
Enrolled by DHHS.

A DSN Board or qualified provider of Residential Habilitation that currently serves a specific HASCI Waiver participant in need of Psychological Services must employ or contract with an individual enrolled with SCDHHS as a provider of Psychological Services or must employ or contract with a professional enrolled with SCDHHS as a Licensed Independent Practitioner of Rehabilitative Services (LIPS) provider.
The DSN Board or qualified provider must comply with SCDDSN Psychological Services Standards.

Verification of Provider Qualifications

Entity Responsible for Verification:
DDSN/DHHS
Frequency of Verification:
Upon Enrollment and 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:
Supplies, Equipment and Assistive Technology 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:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ○ **Service is included in approved waiver. The service specifications have been modified.**
- ◉ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Specialized Medical Equipment and Assistive Technology 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 specialized medical equipment and assistive technology will assist the participant to function more independently. Assessment and consultation cannot be used to determine the need for supplies.

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), or Medicaid-enrolled Environmental Access/Consultants/contractors.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
The reimbursement for the Consultation/Assessment may not exceed $300.00.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **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	OT, PT, Rehabilitation Engineering Technologists, Assistive Technology Practitioners,Assistive Technology Suppliers, Environmental Access/Consultants/contractors

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supplies, Equipment and Assistive Technology Assessment/Consultation

Provider Category:
Agency
Provider Type:
OT, PT, Rehabilitation Engineering Technologists, Assistive Technology Practitioners,Assistive Technology Suppliers, Environmental Access/Consultants/contractors
Provider Qualifications
License *(specify):*
Licensed Medicaid enrolled Occupational (OT) or Physical Therapists (PT), and Rehabilitation Engineering Technologists (RET).
Certificate *(specify):*
Assistive Technology Practitioners (ATP) and Assistive Technology Suppliers (ATS) certified by the Rehabilitation Engineering Society of North American (RESNA), Medicaid enrolled Environmental Access/Consultants/contractors (EACC) certified by Professional Resource in Management (PRIME).
Other Standard *(specify):*
DHHS Medicaid 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:

Supplies, Equipment and Assistive Technology

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14031 equipment and technology

Category 2:	Sub-Category 2:
14 Equipment, Technology, and Modifications	14032 supplies

Category 3:	Sub-Category 3:

Category 4:	Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope)*:

Supplies, Equipment and Assistive Technology means medical supplies and equipment and specialized appliances, devices, or controls necessary for the personal care of a HASCI Waiver participant or to increase his or her ability to perform activities of daily living or interact with others. It includes items needed for life support and ancillary supplies and equipment necessary for the proper functioning of such items. Excluded are items not of direct medical or remedial benefit to the participant.

The service may also include temporary rental of an item, follow-up inspection after items are received, training in use of equipment/assistive technology, repairs not covered by warranty, and batteries/replacement parts for equipment or AT devices not covered by warranty or any other funding sources.

Items funded by the HASCI Waiver may be in addition to supplies and equipment furnished under the Medicaid State Plan or which are not available under the Medicaid State Plan.

Motorized wheelchairs are available under the Medicaid State Plan if medically justified.

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**
- [x] **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
Agency	DDSN/DSN Board/Contracted Providers
Individual	Technicians or professionals certified in the installation and repair of manufacturer's equipment.
Agency	Durable Medical Equipment Provider
Agency	Licensed Contractors
Individual	Rehabilitation Engineering Technologist (RET) certified by Rehabilitation Engineering Society of North American (RESNA)

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supplies, Equipment and Assistive Technology

Provider Category:
Agency
Provider Type:
DDSN/DSN Board/Contracted Providers
Provider Qualifications
License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
The DSN Board or qualified provider must employ or contract with the following, but is responsible to verify and document licensure:
• 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

In addition to the above, the DSN Board or qualified provider may employ or contract with the following for consultation, assessment, and/or follow-up inspection for medical equipment or assistive technology; the provider is responsible to verify and document licensure or certification:

o Licensed Occupational Therapist o Licensed Physical Therapist
o Rehabilitation Engineering Technologist (RET) certified by Rehabilitation Engineering Society of North American (RESNA)
o Assistive Technology Practitioner (ATP) certified by Rehabilitation Engineering Society of North American (RESNA)
o ATP Supplier certified by Rehabilitation Engineering Society of North American (RESNA)
o Environmental Access Consultant/contractor certified by Professional Resources in Management (PRIME)

Verification of Provider Qualifications
Entity Responsible for Verification:

DDSN
Frequency of Verification:
Annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supplies, Equipment and Assistive Technology

Provider Category:
Individual
Provider Type:
Technicians or professionals certified in the installation and repair of manufacturer's equipment.
Provider Qualifications
License *(specify):*
Yes, Section 33-1-200 et. Seq. thru 33-1-420
Certificate *(specify):*

Other Standard *(specify):*
Contracted with DDSN/ Medicaid Agency
Verification of Provider Qualifications
Entity Responsible for Verification:
DDSN; Medicaid Agency
Frequency of Verification:
Upon enrollment or service authorization

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supplies, Equipment and Assistive Technology

Provider Category:
Agency
Provider Type:
Durable Medical Equipment Provider
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Enrolled with SCDHHS
Verification of Provider Qualifications
Entity Responsible for Verification:
SCDHHS
Frequency of Verification:
Upon Enrollment

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supplies, Equipment and Assistive Technology

Provider Category:
Agency
Provider Type:
Licensed Contractors
Provider Qualifications
License *(specify):*
Certificate *(specify):*
Other Standard *(specify):*
Enrolled with DHHS
Verification of Provider Qualifications
Entity Responsible for Verification:
SCDHHS
Frequency of Verification:
Upon Enrollment.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supplies, Equipment and Assistive Technology

Provider Category:
Individual
Provider Type:
Rehabilitation Engineering Technologist (RET) certified by Rehabilitation Engineering Society of North American (RESNA)
Provider Qualifications
License *(specify):*
Certificate *(specify):*
Certified by Rehabilitation Engineering Society of North American (RESNA)
Other Standard *(specify):*
Contracted with DDSN; Medicaid Agency
Verification of Provider Qualifications
Entity Responsible for Verification:
DDSN; Medicaid Agency
Frequency of Verification:
Upon enrollment and authorization

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.*

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

Case management is provided by the Department of Disabilities and Special Needs (DDSN) through contracts with:

1. Disabilities and Special Needs (DSN) Board providers
2. Other approved/qualified providers

DSN Boards are established in the SC Code of Laws. DSN Boards are the designated Planning and Coordinating Entity for people with disabilities and special needs in their respective counties. In addition, DDSN has an ongoing open solicitation to allow organizations/persons interested in providing services funded by DDSN to go through a process to become qualified, including appropriate licensure or certification. This process is done in conjunction with the state's procurement office. Once approved, a provider's name is added to a list available to all consumers.

All individual case managers, regardless of provider type, must meet the following minimum qualifications:
• Must hold at least a Bachelor's degree in social work or a related field from an accredited college or university or hold a Bachelor's degree in an unrelated field from an accredited college or university and have at least one (1) year of experience working with the target population

Case management staff facilitate initial waiver enrollment, assess service needs, prepare and monitor implementation of the support plan, complete level of care reevaluations, and monitor the health and welfare of the participants while promoting maximum independence. Case managers discuss any HASCI Waiver amendment or renewal changes with participants and revise service plans as needed.

DDSN assists individuals in identifying alternate services and supports, if the HASCI Waiver cannot meet his/her needs.

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):

Community Residential Care Facilities, Home Health Agencies, Personal Care Agencies, Attendants, Adult Day Health Care Agencies, Nursing Homes providing respite and DDSN direct care staff are required to have background checks completed by South Carolina Law Enforcement Division (SLED).

When a provider is unable to verify South Carolina residency or residency in another state for the 12 months preceding the date of the employment application, OR, the applicant is expected to work directly with children from

birth to age 18, the provider must request a Federal Criminal Record Check from the Federal Bureau of Investigation prior to employment. The results include reports from both the applicable state law enforcement agency and the FBI. The Federal Criminal Record Check is done via an electronic fingerprint scan. No other type of criminal background check can be substituted for a Federal Criminal Record Check when a Federal background check is required.

Compliance reviews are conducted by DDSN's QIO and DHHS staff to ensure mandatory investigations have been conducted.

Nursing Homes, Community Residential Care Facilities, Home Health Agencies, Adult Day Health Care Agencies and Attendants direct care staff are required by law to have background checks completed. These are state-level investigations performed by SLED. As part of licensure inspections, the state health department ensures that mandatory investigations have been 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

DHHS staff monitor contract compliance for nursing and personal care providers at least every eighteen months.

Additionally, abuse registry screenings must be completed for all staff of DDSN-contracted service providers. The SC Department of Social Services maintains the abuse registry list and screens those names submitted by contracted providers against the registry. DDSN, through its QIO and licensing reviewers, ensures that mandated screenings have been conducted.

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 HASCI Waiver services may be made to certain family members who meet South Carolina Medicaid provider qualifications. The following family members may not be reimbursed: the spouse of a Medicaid participant; a parent of a minor Medicaid participant; a step-parent of a minor Medicaid participant; a foster parent of a minor Medicaid participant; a court-appointed guardian of a Medicaid participant; any other person legally responsible (sole, joint or otherwise) for the Medicaid participant. A family member that is a primary caregiver will not be reimbursed for Respite Care services. All other qualified family members may be reimbursed for the provision of services as specified in the Waiver Service Summary. Should there be any question as to whether a caregiver falls into any of the categories listed above, SCDHHS 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 may contact either SCDHHS or SCDDSN directly to obtain information on the enrollment/contracting process; the procedures used to qualify providers; and, the timeframes/deadlines associated with the various process steps. Additionally, potential providers can find information on the SCDHHS and SCDDSN websites.

DDSN and/or DHHS assess providers against established criteria and then approve providers to provide those services for which they qualify. DDSN and/or DHHS ensure providers continue to meet established criteria for providing services as part of ongoing provider reviews.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

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

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:
Proportion of existing waiver service providers that meet required licensing, certification and other state standards. N = the number of existing waiver service providers that meet required licensing, certification and other state standards / D = the total number of existing waiver service providers reviewed

Data Source (Select one):
Other
If 'Other' is selected, specify:
SCDDSN 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: SCDDSN contractor	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Periodic reviews of behavior support & psychological services providers within 4-year timeframe. Periodic reviews of residential habilitation & day habilitation providers within 18-month timeframe.	

Data Source (Select one):
Other
If 'Other' is selected, specify:
DHHS Provider Enrollment

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: Per CMS revalidation requirements.	

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 new waiver service providers that meet required licensing, certification and other state standards prior to the provision of waiver services by provider type N = the number of new waiver service providers that meet the required licensing, certification and other state standards prior to the provision of waiver services / D = the number of new waiver service providers reviewed

Data Source (Select one):
Other
If 'Other' is selected, specify:
DHHS Provider Enrollment

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: Upon application	

Data Source (Select one):
Other
If 'Other' is selected, specify:
DDSN review

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: Upon Application	

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):*

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 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:
Proportion of existing non-licensed/non-certified providers that meet waiver requirements N = the number of existing non-licensed/non-certified providers that meet waiver requirements D = the total number of existing non-licensed/non-certified providers reviewed

Data Source (Select one):
Other
If 'Other' is selected, specify:
DHHS 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: As warranted	

Data Source (Select one):
Other
If 'Other' is selected, specify:
DHHS provider compliance reviews

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

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 based on size of the provider
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: DDSN QIO reviews are conducted on a 12 to 18 month cycle based on a provider's past performance	

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:
Proportion of new non-licensed, non-certified providers that meet waiver requirements N = the number of new non-licensed, non-certified providers that meet waiver requirements / D = the total number of new non-licensed, non-certified providers reviewed

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:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Upon application	

Data Source (Select one):
Other
If 'Other' is selected, specify:
DHHS provider compliance reviews

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

☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Upon application	

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:

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:
Proportion of qualified providers that meet training requirements N = the number of qualified providers that meet training requirements / D = the number of qualified providers reviewed

Data Source (Select one):
Other
If 'Other' is selected, specify:

DHHS 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:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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 based

		on size of the provider
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: DDSN QIO reviews are conducted on a 12 to 18 month cycle based on a provider's past performance	

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. See Appendix B-QI-a-ii for further information on the sampling methodology

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Findings from SCDHHS and SCDDSN QIO reviews are documented and delivered to providers. Providers are required to develop corrective action plans to address areas of non-compliance. Follow-up reviews are conducted as appropriate. SCDHHS reviews are documented and stored in various physical and electronic files. DDSN QIO reviews are documented and stored on a web-based portal.

DHHS recoups funds from DDSN and/or providers as appropriate.

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

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

◉ **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.

There are currently no settings that fully comply with the federal HCB Settings requirements.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:
Support Plan

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

The framework below has been approved by CMS as the basis for transitioning to conflict-free processes.

Phase 1 (Beginning July 1, 2020):
1. SCDHHS will update waiver policy for new beneficiaries coming into the waiver system to reflect that they must select one entity for case management and a different entity for delivery of any HCB services.
2. Providers will identify beneficiaries who currently receive both case management and HCB services from them and provide that information to SCDHHS and SCDDSN.
3. SCDHHS and SCDDSN will work with providers to ensure administrative separation and conflict mitigation strategies exist between staff doing case management and staff delivering direct services for current waiver beneficiaries receiving both from a single entity during the transition.
4. SCDHHS and partners will educate beneficiaries and providers about upcoming changes.

Phase 2 (Beginning January 1, 2021):
1. SCDHHS will develop and implement a transition plan addressing all aspects of the move from current state to a conflict-free approach.
2. Each provider will create a transition plan, to be approved by SCDDSN, that details its approach to moving a percentage of its conflicted beneficiaries to the individual choice model for conflict-free case management each year.
   a. Year 1: Providers must transition at least 20% of beneficiaries
   b. Year 2: Providers must transition at least an additional 30% of beneficiaries
   c. Year 3: Providers must transition the remaining beneficiaries

Phase 3 (Beginning January 1, 2021): SCDDSN and SCDHHS will monitor each provider's progress.

Phase 4 (Beginning January 1, 2024): All waiver beneficiaries will have one entity providing case management services and a different entity(ies) providing direct services in compliance with 42 CFR 441.301(c)(1)(vi).

In addition to the implementation of conflict-free case management described above, beneficiaries are given the opportunity to change case managers and/or direct service providers at least annually. Beneficiaries have the right to request a different case manager and/or direct service provider at any time.

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 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 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/legal guardian/parent 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, 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 Plan is developed prior to the waiver enrollment, updated as needed, and a new Plan is completed within 365 days.

Parents/legal guardians 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, parent/legal guardian, knowledgeable professionals and others of the participant, parent/legal guardian’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 support 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 plan will include a statement of the participant’s need; indication of whether or not the need relates to a personal goal; the specific service to meet the need; the amount, frequency, duration of the service; and the type of provider who will furnish the service.

The roles and responsibilities of the WCM/EI, participant, the parent/legal guardian for each service will be discussed during planning. The WCM qualified provider will have primarily responsibility for coordinating services but must rely on the participant, parent/legal guardian 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 HASCI 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 plan will be made as needed by the WCM provider when the results of monitoring or when information obtained from the participant, parent/legal guardian, and/or service providers indicates the need for a change to the plan.

Every calendar month the WCM provider will contact the participant/family to conduct non face to face monitoring of the 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 update the Plan.

On at least a quarterly basis there will be a review of the entire Plan to determine if updates are needed. This will be conducted during a face to face contact with the participant/family during which the effectiveness, usefulness, and benefits of the Plan will be discussed along with the participant's/family's satisfaction with the services/providers. During two of four quarterly visits each Plan year the WCM/EI provider will visit the participant in the home/natural environment to monitor the health and welfare of the participant's living arrangements, as well as, any changes in the family dynamics which might impact the needs of the participant.

Amendments to the plan will be made as needed by the WCM provider based on the results of plan monitoring or when information obtained from the participant, his/her legal guardian, and/or service providers indicate the need for a change to the Plan.

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.

Waiver participants' needs, including potential risks associated with their situations, are assessed and considered during the annual planning process. The plan of service (support plan) document includes a section for a description of a back-up plan to be implemented during an emergency/natural disaster and a description of how care will be provided in the unexpected absence of a caregiver/supporter.

DDSN utilizes a tool which globally assesses the participant's current situation including the anticipated and expected ability of caregivers to continue to provide care, the condition of equipment, and safety concerns. Identified needs are addressed in the service plan which includes a section dedicated to emergency/back-up planning. Common types of back-up arrangements include the use of family members, roommates, friends or other paid/unpaid support to provide for care needs in the absence of the regular caregiver.

In addition, the support plan includes sections that outline the responsibilities of the waiver participant/representative and the responsibilities of the case manager. Back-up plans are developed and incorporated into all participants Support Plans (service plans).

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 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. Participants are encouraged to phone providers with questions, ask friends about their experiences with providers and utilize other information sources in order to select a provider.

Additionally, participants are supported in choosing providers by being encouraged to contact support and advocacy groups such as but not limited to the Arc of South Carolina, the Brain Injury Association of South Carolina, and the

South Carolina Spinal Cord Injury Association. Participants are encouraged to ask friends and peers about provider websites, and other resources of information to assist them in choosing a provider. Participants, families, legal guardians and/or representatives may request a list of providers of specified waiver services when service needs change, or when a change is requested, or when selection of another provider is needed.

The service directory provider list is available on SCDDSN website @ http://ddsn.sc.gov/consumers/findaprovider/Pages/QualifiedServiceProvidersList.aspx

Participants may also access the SCDHHS Medicaid Provider Directory @ http://www1.scdhhs.gov/search4provider/Default.aspx

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. A sample of participant plans are reviewed by DDSN and results shared with the case manager and his/her supervisor so that corrections can be made if needed. These results are also shared with DHHS in an annual report.

DHHS QA reviews service plans on an annual basis. The information included in the person-centered plan contains specific documentation such as: the participant's name and demographic information; the plan outlines the participant's individual strengths/interests, goals and objectives, amount, frequency, duration of services, type of providers performing the services, and includes an emergency plan. The plan documents the evaluation of actual results and satisfaction of the services and supports the individual waiver participant is receiving.

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:

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 case manager is responsible for monitoring the implementation of the service plan and participant's health and welfare.

The monitoring and follow up methods include:
At a minimum, the Case manager will make contact with the participant, family, legal guardian, and/or representative every 60 calendar days. -Every 180 calendar days, the Case manager will make a face-to-face contact with the participant, family, legal guardian and/or representative. -At least every 6 months, the Case managers will complete a Support Plan review in consultation with the participant, family, legal guardian and/or representative. -At least every 365 days from the date of the previous plan, or more often if the participant needs change, a new Support Plan will be developed by the Case manager in consultation with the participant, family, legal guardian, and/or representative.

- Participants have access to waiver services identified in the service plan (e.g. has the participant encountered problems in securing services authorized in the plan?); DDSN policy dictates the frequency with which monitoring must occur and the elements that must be included. Monitoring is documented using a standardized format that includes the noted elements along with actions to be taken when concerns are noted. Participants/families are given information about all service providers from which they may choose. Monitoring is reviewed by DDSN as part of its quality assurance.

- Services meet the needs of the participant; The State utilizes a standardized assessment tool to identify all the needs of the waiver participants. Once all needs are identified and prioritized, case managers explain the available service options to the waiver participants. Participants are given the names of all available providers of needed services from which they may choose. Their choice is documented. DDSN 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.

- Participant health and welfare is assured; The QIO for quality assurance and licensing measures compliance with identified indicators related to health and welfare, approves all required plans of correction, and conducts a follow-up review to ensure successful remediation. In addition, the QIO has the perspective of viewing the participant record, as a whole, and may make additional recommendations. DDSN monitors all allegations of abuse, neglect and exploitation and other critical incidents. DSN tracks and monitors the reporting process, as well as follow-up and prevention strategies. Case managers also review the health, safety and welfare of participants during routine monitoring of a participant's Support Plan.

- Participants exercise free choice of providers; DDSN 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.

- Participants have access to non-waiver services identified in the service plan, including access to health services. The QIO measures compliance approves all required plan of correction and conducts a follow-up review to ensure successful remediation.

In addition to the QIO reviews, DDSN also ensures that the service plans and annual assessments are reviewed through an internal random selection review process. Random review samples are selected by DDSN and the names of waiver participants selected are tracked in a database. Using this sample, DDSN staff review plans of those participants selected. Once a plan is reviewed, feedback is provided to the provider. It is the responsibility of the Supervisors to ensure that Case managers complete indicated corrections. DDSN tracks this quality assurance activity in detail and uses findings to direct its training and technical assistance efforts.

DDSN maintains an electronic documentation system, Therap, in which the annual assessments and support plans are completed. The guidelines for completing the DDSN case management annual assessment require a response to each question/item on the assessment. The system will not allow the user to complete the assessment until a response has been given for each question/ item. 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 Support 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.

Additionally, to ensure prompt follow up of identified problems, including problems identified by participants, service providers, and others; DDSN 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. For each finding noted in the QIO report, the provider is required to submit a plan of correction to the QIO and the QIO will conduct 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.

DDSN 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 quarterly counterpart meetings with DDSN personnel and representatives of the SC Human Services Provider Association. After much collaboration and the opportunity for public comment, policy revisions are implemented as needed. Current and proposed DDSN Directives and Standards are available to the public for review at any time on the DDSN Web-site @ www.ddsn.sc.gov/aboutddsn.

Information derived from monitoring is compiled and reported to the State by DDSN. This information that is provided is waiver specific data regarding the QIO's measurement of service planning and implementation compliance indicators. Based on the results of the QIO reviews, DDSN provides this information to the state electronically. DDSN may provide additional training and/or technical assistance to providers as needed. Policy changes may also be implemented as a result of the review.

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:*

Monitoring is documented using a standardized format that includes the noted elements along with actions to be taken when concerns are noted. As appropriate, when concerns are noted, participants/families are given information about all service providers of needed services from which they may choose. Monitoring is reviewed by DDSN as part of its quality assurance/compliance process.

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

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

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:

Plans include services and supports that are consistent with the needs, health and safety risk factors, and goals identified in the comprehensive assessment. N=The number of plans reviewed that include services and supports that are consistent with the needs, including health and safety risk factors, and goals identified in the comprehensive assessment. /D=Total number of files 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 is 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 Contractor	☐ **Annually**	☑ **Stratified** Describe Group: Stratified Sampling Approach 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 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 participant's 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:
Participants whose plans are developed at least annually and revised when warranted by change in participants needs in accordance with State policy. N = The number of HASCI Waiver participants whose plans were developed at least annually and revised when warranted by a change in the participants needs in accordance with State Policy. /D = The total number of HASCI 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 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.	

Data Source (Select one):
Other
If 'Other' is selected, specify:
DHHS Focus Review

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 Warrented	

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 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:
Proportion of participants who are receiving the services and supports in the type, amount, frequency, and duration as specified in their plans in accordance with HASCI Waiver policy. N = The number of participants who are receiving services and support indicated by type, amount, frequency and duration as indicated by their plan. /D = The number of HASCI Waiver participant 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:
	☐ **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:

Performance Measure:
Waiver Case Manager must complete the required non face to face contact each month with the waiver participant/family per policy. N = The number of completed non face to face contacts. /D = The number of required non face to face contacts.

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 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: DDSN QIO Contractor	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Waiver Case Manager must complete four (4) quarterly face to face visits with the participant/family during each plan year. N = The number of completed quarterly face to face visits. /D = The total number of required 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:	☐ **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 based 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: DDSN QIO Contractor	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Waiver Case Manager must complete two (2) quarterly face to face visits with the participant/family in the home/natural environment during each plan year per policy. N = The number of completed quarterly face to face visits in the home/natural environment. /D = The total number of required 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):*
	☐ **Weekly**	☐ **100% Review**

☐ **State Medicaid Agency**		
☑ **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 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: DDSN QIO Contractor	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** 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:
Proportion of newly enrolled HASCI Waiver participant records which contained a completed and signed Freedom of Choice form that specifies choice was offered between waiver services and institutional care in accordance with waiver policy. N = The number of HASCI Waiver participants who were offered choice of qualified providers. /D = The total number of HASCI Waiver files reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DDSN QIO QA 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 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: 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**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	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. See Appendix B-QI-a-ii for further information on the sampling methodology

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
When the Quality Improvement Organization (QIO) finds an indicator out of compliance, they will record the citation in the provider's Quality Assurance report. Upon receipt of the report, the provider will have 30 days to submit a Plan of Correction (POC) to address individual and systemic remediation efforts. The QIO will then approve the POC or return it to the provider with a request for additional information. Approximately six months after the POC is approved, the QIO will conduct a follow-up review with the provider to ensure implementation of the POC and to determine if the remediation was successful. DDSN has also established benchmarks for technical assistance to be coordinated by DDSN staff. The technical assistance is an ongoing process that may incorporate on-site instruction or training through counterpart meetings. Lower scoring providers may also be reviewed by the QIO on a more frequent basis. DDSN tracks all QIO reporting information, including Appeals, the Plans of Correction, Follow-up, and remediation. All documentation is maintained on the QIO Portal and is available for DHHS review. This information is analyzed to determine provider specific and system-wide training and technical assistance issues. The frequency of data aggregation and analysis is annually. 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.

The HASCI Waiver offers the participant an option to direct Attendant Care/Personal Assistance Services with employer authority. A participant's eligibility for Self-Directed Attendant Care is assessed through the use of the DDSN Prescreening for Participant-Directed Care tool, which relies on the participant's current level of care evaluation. The assessment is performed by the participant's case manager. If a participant lacks appropriate behavior, sufficient cognitive ability and/or communication skills to safely self-direct his own care, then a Responsible Party (RP) may be designated to direct the care on behalf of the participant. If it is determined the participant can improve in behavior, cognitive functioning and/or communication, the case manager will assist in finding resources for behavior supports and/or training.

Case managers provide information to the participant and/or RP about participant direction as an option, including the benefits and responsibilities. If the participant or RP are interested in participant direction, additional information is shared concerning risks, liabilities, the role of the FMS, and, the hiring and management of workers. Independent advocacy entities and other participants are available to support participants who direct their services.

Even if a participant chooses to direct his services, the case manager continues to monitor service delivery and the status of the participant's 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:

1) Licensed CRCF (up to sixteen individuals unrelated to proprietor)
2) Private residence
3) Temporary living arrangement such as a hotel/motel, shelter or camp

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

Only participants or responsible parties (RPs) that can safely and effectively direct their care are approved for self-direction of services. The participant or RP must have no communication or cognitive deficits that would interfere with their direction of services.

The RP may be a relative or any other person who is not also a paid provider of HASCI Waiver services received by the participant. The RP must have a strong personal commitment to the participant as well as knowledge of the participant's condition/functioning. The RP must understand and assume the risks and responsibilities of directing the participant's care.

The case manager performs a capability screening utilizing a standardized tool. If the participant does not pass the assessment, a RP may direct care if he/she passes the RP version of the assessment. The screening tool 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 - communication, cognitive patterns, and mood and behavior patterns. The communication section assesses the ability of the participant/RP to make themselves understood. The cognitive patterns section evaluates short-term memory and cognitive skills for daily decision making. The mood and behavior patterns section assesses sad/anxious moods and other aspects of behavior. The assessment results are shared with the participant/RP. If the participant/RP disagrees with the results, they may appeal the decision.

Once a participant or RP successfully passes the screening, a referral is made to the University Of South Carolina's School Of Medicine Center for Disability Resources for further validation by a registered nurse. Under a contract between SCDDSN and the USC CDR, RNs assess participants or RPs through interviews and visits, if necessary,

from the perspective of the specific care to be provided. Once the RN has confirmed that the participant or RP is capable of directing his/her care and a provider has been assigned, the RN oversees a match visit. During the match visit, the RN observes the participant or RP directing the caregiver.

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.

The participant and/or responsible party (RP) is/are furnished with information about participant direction during several steps of the process.

Before and after the participant's enrollment in the waiver, the case manager shares general information about self-direction of services as part of an overall introduction to the services provided through the waiver. As part of this activity, the case manager provides a brochure with information about this option.

If a participant expresses interest in pursuing self-directed services, the case manager shares extensive information regarding the benefits and responsibilities as well as information about risks, liabilities, the role of the financial manager, the hiring and management of workers, and the community supports available.

Once a participant (or RP) successfully passes a screening deeming them capable to direct their care, the participant is referred to a RN as described in the previous section. The RN covers the self-direction of services with the participant (and/or RP) in great detail according to the language in DDSN's DHHS-approved policy from the perspective of the services the participant will be receiving.

If a participant chooses not to take advantage of the self-direction option, the case manager continues to assess the participant's interest on an annual basis or at the request of the participant.

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 (responsible party) subject to DHHS and DDSN policy.

A responsible party (RP) may be a relative or any other person who is not also a paid provider of HASCI Waiver services received by the participant. The RP must have a strong personal commitment to the participant as well as knowledge of the participant's condition/functioning. The RP must understand and assume the risks and responsibilities of directing the participant's care. The RP must agree to a predetermined frequency of contact with the participant.

Sections a., d. and e. describe the intake, assessment and training processes followed relative to participant direction of services. Among other things, these processes are designed to ensure that a representative is well-trained, understands the participant and his/her needs, is willing to make the significant commitment required, and, will function in the best interest of the participant. The case manager monitors service provision on an ongoing basis to ensure the representative continues to function in the best interest of 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
Attendant Care/Personal Assistance 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:

The FMS provider is not a sole source contract.
-The operating agency currently uses an FMS to provide these services to participants. DDSN contracts with the Jasper County DSN Board to perform as the Fiscal Agent for HASCI Waiver participants who choose Self-Directed Attendant Care.
-South Carolina Code of Laws 44-20-250 authorizes SCDDSN to contract directly with its provider network of single or multiple county DSN Boards.
- The FMS entity is paid twice monthly based on an annual contract. The annual contract is negotiated between DDSN and the FMS.
-This is an administrative interagency contract that is not subject to state sole source procurement requirements.

South Carolina Code of Laws 44-20-240 authorizes SCDDSN (operating agency) to contract directly with its provider network of single or multiple county DSN Boards.
-The method of compensating the FMS entity is by an Administrative interagency contract between DDSN and Jasper County DSN Board. The estimated percentage of FMS costs relative to the service costs is two percent (2%).
-Estimated percentage of FMS costs relative to the service costs is based on the administrative dollars as a percentage to the total service dollars. There are approximately $70K in FMS costs for the total approximate service costs of $3.3 million. The estimated percentage of FMS costs relative to service costs is two percent (2%).

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

Payment will occur to the FMS through an administrative grant from the operating agency. The payment does not come from the participant's budget.

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:

- [x] **Assist participant in verifying support worker citizenship status**
- [x] **Collect and process timesheets of support workers**
- [x] **Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**
- [x] **Other**

Specify:

The FMS will verify the participant's verification of the worker's minimum qualifications. UAP conducts all required background checks.

-To assist HASCI Waiver participants who choose Self-Directed Attendant Care, the Fiscal Agent obtains and maintains DHS Form I-9 (Employment Eligibility Verification) for each caregiver employed by the participants. The Fiscal Agent also assists by completing the federal "E-Verify" pre-employment process for each caregiver employed by the participants.

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**
- [x] **Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
- [x] **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 performed to verify that expenditures are accounted for and disbursed according to General Accepted Accounting Practices.

Crowley, Welcher and Associates prepares the independent audit of the Jasper DSN Board, which is the financial management agency for participant-directed attendant care services. The audit is paid for by the Jasper DSN Board, with SCDDSN providing an administrative grant to Jasper which includes the cost of an annual audit. SCDDSN and Jasper receive the official audit. One copy is kept on file with SCDDSN's Cost Analysis Division and another with SCDDSN's Internal Audit Division.

SCDDSN reviews the program for compliance as well as effectiveness, and is responsible for remediation.

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:

For the self-directed attendant care service, waiver case managers will provide detailed information to the participant or responsible party (RP) about participant/RP direction as an option including the benefits and responsibilities of the option. If the participant/RP wants to pursue this service, additional information about the risks, responsibilities, and liabilities of the option will be shared by the waiver case manager. Information about the hiring, management and firing of workers as well as the role of the Financial Management System is also provided. Once the participant has chosen to direct their services, waiver case managers continue to monitor service deliver and the status of the participant's 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
Private Vehicle Assessment/Consultation	☐
Behavioral Support Services	☐
Health Education for Participant-Directed Care	☐
Private Vehicle Modifications	☐
Respite Care Services	☐
Pest Control Bed Bugs	☐
Supplies, Equipment and Assistive Technology Assessment/Consultation	☐
Physical Therapy	☐
Psychological Services	☐

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Supplies, Equipment and Assistive Technology	☐
Speech and Hearing Services	☐
Incontinence Supplies	☐
Peer Guidance for Participant-Directed Care	☐
Medicaid Waiver Nursing	☐
Personal Emergency Response Systems	☐
Attendant Care/Personal Assistance Services	☐
Employment Services	☐
Career Preparation Services	☐
Environmental Modifications	☐
Occupational Therapy	☐
Waiver Case Management (WCM)	☐
Pest Control Treatment	☐
Residential Habilitation	☐
Day Activity	☐

☑ **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:

-DDSN contracts with the University of South Carolina (USC) School of Medicine, Center for Disability Resources (CDR) to provide information and other supports for participants who choose Self-Directed Attendant Care.

-Information and supports are for participants choosing self-directed care that is provided by USC-CDR through an administrative contract with DDSN.

-The method of compensating entities for furnishing information and assistance supports is through an Administrative interagency contract between DDSN and USC-CDR. The contracting entity is reimbursed on a quarterly basis using actual expenses submitted by the contracting entity to DDSN.

-A licensed RN employed by USC-CDR assists the participant or Responsible Party as follows:
• Reviews all requirements and procedures to be the "Employer of Record" with the participant or Responsible Party (Employer) and each prospective caregiver (Attendant);
• Assists with completing necessary paperwork, care schedules, and back-up arrangements;
• Obtains required criminal history background check and documentation of First Aid Training and TB testing for each perspective caregiver;
• Notifies the Fiscal Agent when each perspective caregiver has completed all requirements;
• Maintains a file on each caregiver (Attendant) with documentation that requirements are met;
• Provides guidance for recruiting and training caregivers;
• Observes participant or Responsible Party and caregivers in actual provision of personal care; and
• Assists with problem resolution.

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:

Protection and Advocacy of South Carolina has agreed to provide this advocacy when requested. The Case manager will provide their phone number and contact names to participants.-The advocacy organization does not provide direct services.

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 case manager will accommodate the participant by providing a list of qualified providers they can select from to maintain service delivery. The case manager and the operating agency will work together to ensure the participant's health and safety 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 the participant or his representative are no longer able to communicate or if they experience cognitive deficits which keep them from acting in their or the participant's best interest, the case manager will transition services from participant direction to agency directed services.

The case manager will assist the participant/legal guardian to select one or more agency providers of Attendant Care/Personal Assistance; authorized services will be transferred. The authorization of agency directed services will be coordinated by the case manager.

The operating agency will use written criteria in making this determination. The participant and/or representative will be informed of the opportunity and means of requesting a fair hearing, choosing an alternate provider and the plan will be revised to accommodate changes.

Additionally, a participant may be terminated from Self-Directed Attendant Care for any of the following:
-health and/or safety is jeopardized due to inadequate care;
-demonstrated inability to effectively supervise caregivers;
-lack of cooperation in following required procedures (such as documenting caregiver time) ;
-falsifying information concerning use of authorized units of Attendant Care/Personal Assistance;
-criminal activity (such as illegal drug use/dealing, child pornography, fencing stolen items).

-To ensure the continuity of services and participant health and welfare the case manager will coordinate the participant's /legal guardian's selection of one or more agency providers of Attendant Care/Personal Assistance to ensure continuity of care and authorized services.

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	100	
Year 2	120	
Year 3	140	
Year 4	160	
Year 5	180	

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 UAP.

☑ **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.**
☑ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**
☐ **Determine staff wages and benefits subject to State limits**
☑ **Schedule staff**
☑ **Orient and instruct staff in duties**
☑ **Supervise staff**
☑ **Evaluate staff performance**
☑ **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 case manager will provide written notification and verbal explanation to the individual applicant or the legal guardian during a meeting concerning the SCDDSN Reconsideration and SCDHHS Appeal (Fair Hearing) prior to enrollment and when the individual applicant signs the Freedom of Choice (FOC) form.

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).

Whenever there is an adverse decision or action related to enrollment in the HASCI Waiver or subsequent receipt of services, the case manager must provide written notification to the applicant or participant or the legal guardian, including reason for the adverse decision or action. Written information concerning SCDDSN Reconsideration and SCDHHS Appeal (Fair Hearing) must also be provided. The case manager will assist in filing a written reconsideration if necessary.

Copies of all notices of adverse action and Fair Hearing information are maintained in the participant's case management file.

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

The case manager must offer a participant or legal guardian assistance to request DDSN Reconsideration and/or SCDHHS Appeal (Fair Hearing). The participant or legal guardian may also seek assistance from other persons.

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

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

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

The participant is informed by the case manager that services will continue during the period that the participant's appeal is under consideration by written notification (letter) concerning the SCDDSN Reconsideration and SCDHHS Appeal (Fair Hearing) that is provided to the participant or legal guardian includes the following statement:
"In order for affected Waiver services to continue during the SCDDSN Reconsideration process and the SCDHHS Medicaid Appeal process, the consumer, 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 affected Waiver services must be specifically requested in the request for SCDDSN Reconsideration. If the adverse decision/action is upheld, the consumer or legal guardian may be required to repay the cost of affected Waiver services received during the time of the reconsideration/appeal processes."

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

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

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

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

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

Appendix F: 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:

The Department of Disabilities and Special Needs 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 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 arise to the level of critical incidents, ANE or waiver matters that would normally follow the reconsideration/appeal process. People are encouraged to first seek resolution 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.

NOTE: The participant shall be informed in all circumstances that filing a grievance or making a complaint is not a prerequisite or substitute for a fair hearing. These are two totally separate processes.

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 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.

The reporting of Critical Incidents as defined by DDSN Directive(100-09-DD) must be followed. A critical incident is an unusual, unfavorable occurrence that is: a) not consistent with routine operations; b) has harmful or otherwise negative effects involving people with disabilities, employees, or property; and c) occurs in a DDSN Regional Center, DSN Board facility, other service provider facility, or during the direct provision of DDSN funded services (e.g., if a child receiving case management services sustains a serious injury while the case manager is in the child's home, then it should be reported as a critical incident; however, if the case manager is not in the home when the injury occurred then it would not be reported). An example of a critical incident includes but is not limited to possession of firearms, weapons or explosives or consumer accidents which result in serious injury requiring hospitalization or medical treatment from injuries received. Reports of critical incidents are required to be made to the operating agency within 24 hours or the next business day of the incident.

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.

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 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.

The reporting of critical incidents should follow the procedures outlined in DDSN Directive 100-09-DD. DDSN Directive 534-02-DD specifically addresses the procedures for preventing and responding to ANE. This Directive sets forth the reporting requirements of state law and also identifies DDSN and its contract provider agencies' legal responsibility for reporting ANE. This 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. Reporting requirements specify that all incidents must be reported to DDSN within 24 hours or the next business day, per Directives 100-09-DD and 534- 02-DD.

-All allegations of abuse/ neglect/ and exploitation and other critical incidents are reported using the DDSN Incident Management System within 24 hours of the incident. An internal management review must be conducted of all allegations of abuse/ neglect/ and exploitation and other critical incidents. Results of all reviews must be submitted on the DDSN Incident Management System within ten (10) working days of the incident or whenever staff first became aware of the incident. The report must contain the results of the review and list recommendations to prevent or reduce where possible the recurrence of such incidents in the future. The Executive Director/CEO or their designee reviews and submits the final report. If the disposition of the allegations of abuse/ neglect/ and exploitation or other critical incident changes or additional information is discovered after the review an Addendum must be completed and submitted via the DDSN Incident Management System within 24 hours or the next business day of the change. For incidents occurring in the Waiver participant's home or other community setting, the South Carolina Department of Social Services will conduct the necessary follow-up with the participant and/or family.

-Based on the contact information in the consumer's plan, the parent/guardian or primary correspondent is notified of the ANE allegation or other critical incident, as soon as possible, in the most expeditious manner possible and is kept informed of the results of the management review to the extent possible, while maintaining confidentiality for all parties involved. Adult consumers who may legally consent may also choose not to disclose individual incidents. At least annually, the adult consumer, with input from those important to him/her will specify who will be contacted should an incident occur. This information is documented and readily available in the person's file. Contact information for consumers under 18 years old is updated in their plans annually and readily available. The parent/guardian or primary correspondent is informed of their right to contact the state investigative agency if they have any questions or concerns regarding ANE allegations. -Examples of the State Investigative Agencies may include the State Law Enforcement Division, the State Long-Term Care Ombudsman's Office, Department of Social Services, or Local Law Enforcement.

-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 is substantiated, the employee will be terminated.

-When there is reason to believe that an adult has been abused, neglected or exploited, mandated reporters have a duty to make a report to DSS or local law enforcement. All alleged abuse and other critical events are also reported to DDSN 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 on 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 person's 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, 534-02-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.

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:
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.

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).

-DDSN policy indicates 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.

-In accordance with DDSN Directive 535-02 DD: Human Rights Committee, each provider must designate and use a Human Rights Committee to review, approve, and monitor individual plans designed to manage inappropriate behavior and other plans that, in the opinion of the Committee, involve risks to individual protection and rights. Individual plans that involve risk, including, but not limited to, those procedures designated by the provider's policies and procedures as being restrictive, require consent pursuant to DDSN Directive 535-07-DD: Obtaining Consent for Minors and Adults.

-Behavior Support Plans are intended to provide positive reinforcement of desired behaviors to the extent possible. Restrictive measures (including restraints) are only implemented to protect the participant and/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: Planned restraint (mechanical or manual) when
approved by the person or his/her legal guardian, the program director/supervisor, an approved provider of behavior support services, the Human Rights Committee (HRC) of the Executive Director; Mechanical restraints to allow healing of injury produced by an inappropriate behavior when approve be the person or his/her legal guardian, the program director/supervisor, an approved provider of behavior support services, the HRC, and the Executive Director; Psychotropic medication when approved by the person or legal guardian, the program director/supervisor, the physician, an approved provider of behavior support services, HRC, and the Executive Director.

-Restraint is defined as a procedure that involves holding an individual (i.e., manual restraint) or applying a device (i.e., mechanical restraint) that restricts the free movement of or normal access to a portion or portions of an individual's body. The following types of restraints may be used:

*The following types of restrictions are specifically prohibited:
(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 DDSN consumer discipline peers;
(6.) Prone (i.e., face down on the floor with arms folded under the chest) basket-hold restraint. (7.) Timeout rooms.
(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 use or inappropriate use of restraints would be considered abuse by the State. Methods used to detect abuse include staff supervision, identification of situations that may increase risk, and continuous intervention by the Program Director or Supervisor are employed to detect inappropriate use of restraints/seclusion.

-DDSN utilizes an independent 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 is 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.

-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 Behavior Support Service Standards require that all restrictive interventions be documented. This documentation must be reviewed at least monthly by a designated staff member and an approved provider of Behavior Support Services. Data collected must include a graph on which data is graphed in a manner which notes changes in BSP procedures, psychotropic medications, and significant environmental variables and over sufficient duration to facilitate detection of trends and patterns.

-For any participant that has a plan for restrictive interventions, including restraints, a Behavior Support Plan must be developed by an approved provider and the plan must also be approved by the Human Rights Committee. DDSN Behavior Support Service Standards require that all restrictive interventions be documented. This documentation must be reviewed at least monthly by a designated staff member and an approved provider of Behavior Support Services. Data collected must include reports and graphs on which data is graphed in a manner which notes changes in BSP procedures, psychotropic medications, and significant environmental variables and over sufficient duration to facilitate detection of trends and patterns. The graphs provide the reviewer a visual method of tracking targeted behaviors to determine the success of the Behavior Support Plan.

-DDSN utilizes an independent 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. 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 Human Rights Committee (HRC) regarding monitoring programs that include restraint. DDSN monitors compliance with policies through its compliance reviews conducted by the QIO and through its licensing reviews.

-Contract compliance review and licensing review reports are provided to DHHS per the requirements of the MOA. Traditional survey methods including record reviews, staff interviews, and observation are used 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.

-In addition, restraint procedures may only be included in a Behavior Support Plan when necessary to protect an individual or others from harm and when the procedures are the least restrictive alternatives possible to meet the needs of the person.

-DDSN's QIO determines compliance with DDSN policies on the use of Behavior Support Plans, Restrictive Interventions, and the involvement of the Human Rights Committee. Restraint procedures may only be included in a Behavior Support Plan when necessary to protect an individual or others from harm and when the procedures are the least restrictive alternatives possible to meet the needs of the person.

-Use of restraint is limited to a maximum of one (1) continuous hour. Release from restraint must occur when the person is calm and is no longer a danger to self or others. It should be quite rare for the maximum restraint duration to be used. If the person becomes aggressive again (reaching criterion for restraint), a new restraint can be implemented. In rare circumstances, if a provider/center has valid data to show that, for example, 70 minutes works well and that 60 minutes presented a serious risk to the consumer and staff, an exception to the one hour limit on continuous restraint can be requested from the State Director. Plans that include restraint must also include strategies directed toward reducing dependency on its use. A physician's order for restraint is needed but is not required at the time of each use. The order may be included in the routine medical orders which are renewed per state licensure requirements.

-Mechanical restraint procedures should be designed and used in a manner that causes no injury and a minimum of discomfort. While in mechanical restraint, the individual will be supervised in accordance with his/her plan with documentation of their response to the restraint every 30 minutes with a maximum duration not to exceed one (1) continuous hour unless an exception is granted. This documentation should include the physical condition of the individual (i.e., breathing, circulation).

-When restraint procedures are included in a Behavior Support Plan, approval must be obtained from the person and if the person is not their own legal guardian the legal guardian, the Executive Director and the Human Rights Committee.

-DDSN Behavior Support Service Standards require that all restrictive interventions be documented. This documentation must be reviewed at least monthly by a designated staff member and an approved provider of Behavior Support Services. Data collected must include a graph on which data is graphed in a manner which notes changes in BSP procedures, psychotropic medications, and significant environmental variables and over sufficient duration to facilitate detection of trends and patterns.

-The Behavior Support provider monitors as necessary, but minimally at the frequency specified in the Behavior Support Plan. The QIO also measures compliance with monitoring requirements during the QA review.

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:

- Restrictive procedures (procedures that limit freedom or cause loss of personal property or rights excluding restraint) when approved by the person, his/her legal guardian, the program director/supervision, an approved behavior support provider, and the Human Rights Committee (HRC).

-The States descriptive method to detect the unauthorized use of restrictive interventions is as follows: -Monitoring is conducted continuously through the Program Director or Supervisor, team, a professional who meets Waiver qualifications for Behavior Support, the Case manager, and the Human Rights Committee. The QIO also measures compliance with monitoring requirements during the QA review.

-The required documentation when restrictive interventions are used is the responsibility of each DSN Board or contracted provider that must adopt and implement written policies and procedures governing the assessment, prevention, and management of inappropriate behavior.

- -Each DSN Board or contracted provider must adopt and implement written policies and procedures governing the assessment, prevention, and management of inappropriate behavior. These policies and procedures must specify all facility or program-approved procedures used for inappropriate behavior. A primary focus is on the prevention of problem behavior using functional assessment data to identify appropriate alternative behaviors to teach and/or reinforce. When consequence-based procedures are to be used, each DSN Board/contracted provider must designate these procedures on a hierarchy, ranging from most positive or least intrusive, to least positive or most intrusive. These procedures must address the following: the use of restraints; the use of medications to manage inappropriate behavior; the use of aversive consequences and the analysis of how this will impact the overall quality of life of the individual. All restrictive interventions are documented for review by the approved Behavior Supports provider.

-These procedures must address the following: the use of restraints; the use of medications to manage inappropriate behavior; and the use of aversive consequences.

-For any participant that has a plan for restrictive interventions, including restraints, a Behavior Support Plan must be developed by an approved provider and the plan must also be approved by the Human Rights Committee. DDSN Behavior Support Service Standards require that all restrictive interventions be documented. This documentation must be reviewed at least monthly by a designated staff member and an approved provider of Behavior Support Services. Data collected must include reports and graphs on which data is graphed in a manner which notes changes in BSP procedures, psychotropic medications, and significant environmental variables and over sufficient duration to facilitate detection of trends and patterns. The graphs provide the reviewer a visual method of tracking targeted behaviors to determine the success of the Behavior Support Plan.

-The required education and training of personnel involved in authorization and administration of restrictive interventions includes at a minimum, direct support staff and those who supervise direct support staff must be certified in the crisis management system chosen before performing the skill. When those present are in the care of staff, at least one staff member must, at a minimum, be within a 5 minute response time of any who are not verified. Certified staff must be clearly identified and known to non- certified staff so, if needed, assistance may be obtained. -Per DDSN Policy, at a minimum, direct support staff and those who supervise direct support staff must be certified in the crisis management system chosen before performing the skill. Provider agencies must utilize a crisis management curriculum approved by DDSN. (Examples are MANDT and NCI.) When those present are in the care of staff, at least one staff member must, at a minimum, be within a 5 minute response time of any who are not proficient in the use of the approved curriculum. Certified staff must be clearly identified and known to non-certified staff so, if needed, assistance may be obtained.

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

-In addition, the methods for detecting unauthorized use, over use, or inappropriate/ineffective use of restrictive procedures and ensuring that all applicable state requirements are followed is through monitoring conducted continuously through the Program Director or program supervisor, team, a professional who meets Waiver qualification for Behavior Support, the Case manager, and the Human Rights Committee. The QIO also measures compliance with monitoring requirements during the QA review.

-Methods for overseeing the operation of the incident management system include data collected, compiled, and used to prevent reoccurrence. Documentation must be reviewed at least monthly by a designated staff member and an approved provider of Behavior Support Services. Data is collected by direct support professionals, program managers, and the BSP Provider and will include documentation of any incidents of targeted behaviors, interventions used, and follow-up. The data must also include a graph on which data is graphed in a manner which notes changes in BSP procedures, psychotropic medications, and significant environmental variables and over sufficient duration to facilitate detection of trends and patterns. This information is necessary for team discussion regarding antecedent behavior and targeting prevention strategies.

-DDSN's QIO determines compliance with DDSN policies on the use of Behavior Support Plans, Restrictive Interventions, and the involvement of the Human Rights Committee. DDSN Quality Management Staff also review the data obtained from QA and Licensing reviews as they are completed to determine additional training and/ or technical assistance needs. DDSN also monitors the provider's critical incident reports documenting behaviors that result in restrictive interventions.

- The frequency of oversight activities are conducted through monthly reviews of documentation as described above.

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 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 is responsible for the monitoring of participant medication regimes. This monitoring occurs as part of DDSN's licensing reviews of providers. The review of the tracking, trending and analyzing of this information occurs as part of the QIO review.

-The scope of medication monitoring regularly takes place through the QIO Quality Assurance and Licensing reviews. Each has a role in reviewing service standards and ensuring compliance with policy. Various documents, including medication administration records and medication error reporting forms, are reviewed to ensure consumer safety while promoting maximum independence within the health care provider's orders. Specific measures have been developed for use in the QA and Licensing reviews to track data and monitor compliance with service standards.

-DDSN monitors the use of all medications (prescribed and over the counter). General monitoring is not limited to any specific class of medications, although DDSN Directive 603-01-DD specifically addresses the protocol for Tardive Dyskinesia monitoring for any consumer prescribed antipsychotic medications or other medications associated with Tardive Dyskinesia.

-The frequency of monitoring are through QA reviews that are coordinated on a typical 12 to 18 month cycle (depending on a providers' past performance) and licensing reviews are typically coordinated on an annual basis, depending on the type of facility. Providers are required to review individual medication errors in their monthly Risk Management Committee meetings. In addition to the individual error reports, the providers must also track, trend, and analyze all medication errors to identify systemic errors and develop a plan to address any areas of concern.

-In addition, monitoring is designed to detect potentially harmful practices and necessary follow up for such practices. QA and Licensing reviews are completed to determine additional training and/ or technical assistance needs. DDSN also monitors the provider's medication error rate and reports of critical incidents (additional medical attention due to adverse reaction) that may result from medication errors.

-In accordance with DDSN Directive 535-02 DD: Human Rights Committee, each provider must designate and use a Human Rights Committee to review, approve, and monitor individual plans designed to manage inappropriate behavior and other plans that, in the opinion of the Committee, involve risks to individual protection and rights. Individual plans that involve risk, including, but not limited to, those procedures designated by the provider's policies and procedures as being restrictive, require consent pursuant to DDSN Directive 535-07-DD: Obtaining Consent for Minors and Adults.

-Second-line monitoring is conducted in the use of behavior modifying medications such as: Psychotropic medications will be accompanied by a Behavior Support Plan if the person's problem behavior poses a significant risk to him/herself, others, or the environment (i.e., self-injury, physical aggression or property destruction). PRN orders for psychotropic medications are specifically prohibited.

-Psychotropic medications are reviewed based on the individual's needs as determined by the psychiatrist or physician and at least quarterly in a psychotropic drug review process. Persons involved in this process should include, but are not limited to, the physician, individual receiving supports and, if the individual is not their own legal guardian the legal guardian, an approved provider of behavioral supports, program supervisor, caregiver who knows the individual well, nurse, and psychiatrist, if applicable. This group comprises the psychotropic drug review team. The psychotropic drug review process should provide for gradually diminishing medication dosages and ultimately discontinuing the drug unless clinical evidence justifies that the medication is helping the individual.

-When psychotropic medication is used, the team will specify which behaviors/psychiatric symptoms are target for change and should, therefore, be monitored both for desired effects and adverse consequences/reactions.

-DDSN has followed the general guidelines of the National Coordinating Council for Medication Error Reporting and Prevention (NCC MERP) "Taxonomy of Medication Errors" in developing its Medication Error Reporting Process. DDSN Service Providers are required to develop a data collection system to track, monitor and analyze medication errors/events, including medication error rates. In order to be consistent with "best practice", medication error reduction efforts should possess the capability for both reactive and proactive analysis. Reactive analysis enables the provider to better understand both a specific medication error that has occurred and the analysis of aggregate medication error data. Methods of proactive analysis, on the other hand, include the analyzing of consumer refusals, "near misses" or other unsafe circumstances that may lead to a medication error in the future, and the analysis of errors that have occurred in other systems or settings. Providers are required to categorize the types of errors/events reported in their analysis. Providers are also required to record the agency's error rate (number of errors divided by the total number of medications passed for a given time period) along with the number of errors/events. Error rates are not to be used as a substitute for the actual number of errors/events.

-DDSN reviews the data obtained from QA and Licensing reviews as they are completed to determine additional training and/ or technical assistance needs. DDSN also monitors the provider's medication error rate and reports of critical incidents (additional medical attention due to adverse reaction) that may result from medication errors. For any citations in QA or Licensing Reports, the provider is required to submit a Plan of Correction to address the individual citation and any systemic issues that may have been uncovered. The Plan of Correction is reviewed and approved by the QIO. Approximately 4 to 6 months after the Plan of Correction has been implemented, the QIO conducts a follow-up review to ensure remediation and successful implementation of the Plan of Correction. If the citations are not corrected, an additional Plan of Correction must be completed and subsequent follow-up.

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.

-DDSN has followed the general guidelines of the National Coordinating Council for Medication Error Reporting and Prevention (NCC MERP) “Taxonomy of Medication Errors” in developing its Medication Error Reporting Process. DDSN Service Providers are required to develop a data collection system to track, monitor and analyze medication errors/events, including medication error rates.

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.

-In order to be consistent with “best practice”, medication error reduction efforts should possess the capability for both reactive and proactive analysis. Reactive analysis enables the provider to better understand both a specific medication error that has occurred and the analysis of aggregate medication error data. Methods of proactive analysis, on the other hand, include the analyzing of consumer refusals, “near misses” or other unsafe circumstances that may lead to a medication error in the future, and the analysis of errors that have occurred in other systems or settings. Providers are required to categorize the types of errors/events reported in their analysis. Providers are also required to record the agency’s error rate (number of errors divided by the total number of medications passed for a given time period) along with the number of errors/events. Error rates are not to be used as a substitute for the actual number of 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.

Beginning in January, 2018, providers will begin entering Medication Error information into Therap, DDSN’s Electronic Medical Record. This will provide a real-time analysis of data and assist provider management in identifying trends and any areas needing training and technical assistance. The data will be available for provider risk management committees to use on a monthly basis.

-Monitoring regularly takes place through the QIO Quality Assurance and Licensing reviews. DDSN reviews the data obtained from QA and Licensing reviews as they are completed to determine additional training and/ or technical assistance needs. DDSN also monitors the provider’s medication error rate and reports of critical incidents (additional medical attention due to adverse reaction) that may result from medication errors.

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 a physician order, know the common medications prescribed for the individuals supported and identifying 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.

-Non-licensed staff has access to licensed medical professionals employed or contracted by the provider agency.

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 agency's contract compliance reviews.

Additionally, DDSN requires 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/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)

Review Methods:
-QA reviews are coordinated on a typical 12 to 18 month cycle (depending on a provider's past performance) and licensing reviews are typically coordinated on a bi-annual basis for most residential locations and on an annual basis for day service locations. DDSN Quality Management staff reviews the data obtained from QA and Licensing reviews as they are posted to the QIO portal (within 30 days of review date). This allows DDSN to determine additional training and/ or technical assistance needs and report trends during quarterly QA/ Risk Management meetings with provider agencies. This information is also available for DHHS review on the QIO portal.

Monitoring Methods:
-DDSN reviews the data obtained from QA and Licensing reviews as they are completed to determine additional training and/ or technical assistance needs. DDSN also monitors the provider's medication error rate and reports of critical incidents (additional medical attention due to adverse reaction) that may result from medication errors. For any citations in QA or Licensing Reports, the provider is required to submit a Plan of Correction to address the individual citation and any systemic issues that may have been uncovered. The Plan of Correction is reviewed and approved by the QIO. Approximately 4 to 6 months after the Plan of Correction has been implemented, the QIO conducts a follow-up review to ensure remediation and successful implementation of the Plan of Correction. If the citations are not corrected, an additional Plan of Correction must be completed and subsequent follow-up.

-Data that is acquired to identify trends and support improvement strategies are through the QA and Licensing reviews and through special circumstance reviews that may target a specific area of concern.

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,or its Licensing inspection contractor, SCDHEC.

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.

SCDDSN 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.

Beginning in January, 2018, providers will begin entering Medication Error information into Therap, DDSN's Electronic Medical Record. This will provide a real-time analysis of data and assist provider management in identifying trends and any areas needing training and technical assistance. The data will be available for provider risk management committees to use on a monthly basis.

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, such as 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 Provider's annual reviews.

According to the above definition, there are some 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 SCDDSN and its network of service providers are divided into three(3)categories:

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); and medication given without a prescriber's order.

2) TRANSCRIPTION & DOCUMENTATION ERRORS: Transcription error (i.e., from prescriber's 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; and each organization must develop a reporting system for these events.

Reporting procedures include the following:
-The first person finding the medication error is responsible to report the error or event to supervisory/administrative staff, such as the employee's 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 provider's annual licensing review. The QIO also reviews Medication Error/Event data and the provider's analysis and risk management activities during their scheduled reviews.

-Each provider must adopt a method for documenting follow-up activities such as utilizing a 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 medications. DDSN requires all providers to follow the policy/procedures outlined in the previous responses. DDSN may request all data related to the 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.

-QA reviews are coordinated on a typical 12 to 18 month cycle (depending on a provider's past performance) and licensing reviews are typically coordinated on a bi-annual basis. DDSN regularly reviews the data obtained from QA and Licensing reviews to determine additional training and/ or technical assistance needs and reports trends during quarterly QA/ Risk Management meetings with provider agencies.

-DDSN reviews the data obtained from QA and Licensing reviews as they are completed to determine additional training and/ or technical assistance needs. DDSN also monitors the provider's medication error rate and reports of critical incidents (additional medical attention due to adverse reaction) that may result from medication errors.

-Data acquired to identify trends and support improvement strategies is through the QA and Licensing reviews and through special circumstance reviews that may target a specific area of concern.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. **Methods for Discovery: Health and Welfare**
The state 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:
Incidents of abuse, neglect, or exploitation (ANE) and unexplained deaths (UD) for waiver participants are reported within the required timeframe. N = the number of waiver incidents of ANE and UD that were reported within the required timeframe. /D = total number of waiver reports of ANE and UD.

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:

Performance Measure:
Waiver participants with substantiated incidents of abuse, neglect, and exploitation (ANE). N = the number of substantiated incidents of ANE for waiver participants. /D = the total number of reported incidents of ANE for 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:

Performance Measure:
Participants/legal guardians receive information yearly about how to report ANE. N = The number of participants/legal guardians who receive information yearly. /D = The total number of waiver participants reviewed.

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: 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:
Staff serving waiver participants with substantiated allegations of ANE against them are terminated according to policy. N = the number of staff serving waiver participants terminated for having a substantiated allegation of ANE. /D = Total number of staff serving waiver participants involved in ANE reports where allegations were substantiated against them.

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: As requested by DHHS	

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:
Unusual/unexplained deaths for waiver participants are referred to appropriate State investigative agencies for additional review. N = number of death report reviews for waiver participants that result in an ANE or Critical Incident investigations due to unusual/unexplained circumstances. /D = total number of death reviews for all waiver participants in DDSN-operated waivers.

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: Upon request by DHHS	

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 waiver participants are reported on the incident management system. N = the number of participants with critical incidents reported on the incident management system. /D = the 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 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**

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:

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:
Waiver participants with reported incidents of restrictive interventions that are inconsistent with policy. N = the number of waiver participants with reported incidents of restrictive interventions that are inconsistent with policy. /D = the total number of 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:

DDSN QIO Contractor		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: DDSN QIO Contractor	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **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:
Waiver participants report access to healthcare services as listed on the person-centered plan/assessment per waiver policy. N = the number of waiver participants

who report access to healthcare services. /D = the total number of waiver files reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
DDSN 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: 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**

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:

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. See Appendix B-QI-a-ii for further information on the sampling methodology

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
As abuse, neglect, and exploitation are identified, DDSN is taking action to protect the health and welfare of the participant. DDSN is collecting data and analyzing for trends, and strategies are developed and implemented to prevent future occurrences. DDSN will provide this information to DHHS on an annual basis.

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

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

c. Timelines
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 2)

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;
- 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 2)

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 the Quality Management Systems is to identify positive and negative trends allowing for necessary adjustments to enhance the overall performance of the system.

System improvement activities are designed to ensure that they address all six (6) CMS assurances based on

performance measures.

Timely discovery and remediation of aggregated data allows the state to take the necessary action to improve the system's performance, thereby learning how to improve meaningful outcomes for waiver participants. Information related to each approved waiver program can be stratified by provider, service group, and assurance.

DDSN's Quality Management System has strong formal processes and activities in place for trending, prioritizing, and implementing system improvements. DDSN is continuously reviewing and updating its QMS 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 reports, results of all QIO provider reviews and DHEC licensing/certification reviews.

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

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☑ **Operating Agency**	☑ **Monthly**
☑ **Sub-State Entity**	☐ **Quarterly**
☐ **Quality Improvement Committee**	☑ **Annually**
☑ **Other** Specify: DDSN QIO Contractor; DHHS QIO Contractor	☑ **Other** Specify: DDSN QIO reviews are conducted every 12-18 months 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.

DHHS and DDSN meet periodically to monitor and analyze the effectiveness of system design changes. Any changes recommended to the overall system's design or to any sub-systems can be discussed at any time.

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. Needed changes can be discussed at any time.

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).

The State employs several methods to ensure the integrity of payments made for both self-directed and agency-directed waiver services in different departments within DHHS and DDSN.

Methods employed include the following:
-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 (PI) 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, PI audits any payments to service providers. PI conducts audits on all Medicaid provider types including HCBS providers. Any suspected fraud is referred to the Medicaid Fraud Control Unit (MFCU) which is a division of the South Carolina Office of the Attorney General. Providers to be reviewed are selected based on algorithms and data mining including providers who are outliers on selected parameters such as cost, utilization, and/or other metrics. Providers are also selected for review based on complaints received via the PI hotline or from internal referrals made by divisions within the agency. Reviews include an analysis of claims data and service documentation to detect aberrancies such as up-coding, unbundling, or billing for services not rendered. Claims data originates from the MMIS and is stored in the agency's Business Information System (BIS). Desk reviews and/or on-site reviews may be involved - the type of review is determined on a case-by-case basis. Typically, if the allegation or preliminary investigation indicates a lack of documentation or falsification of documentation, an on-site review is done to lower the chance the provider will attempt to create documentation in response to the review. On-site reviews are also preferred for provider types that have been deemed high-risk. The majority of the reviews conducted are on-site reviews. During a desk review, the provider is required to submit records. Because DHHS does not use extrapolation, we typically review 100% of provider claims within the designated time period; however, when performing a preliminary review, we may only look at a probe sample of 30 records and then expand to a 100% review if the case is opened. If there are no findings to substantiate an allegation during the initial probe, a case is not opened. The timeframe for a review depends upon the allegation and the provider's claim history, but does not exceed five years (as providers are only required to retain records for five years under SC policy). If the initial allegation involves a short time period, the time period could be expanded to determine whether the alleged behavior occurred for a longer time than was reported; likewise, a review time period could be extended if information is obtained that indicates there are additional areas of fraud, waste or abuse than originally believed. A review time period would be reduced if the claims history showed the provider had only billed Medicaid for a shorter period of time than the period used for the initial claims sample. The number of providers reviewed will vary depending on the scope and complexity of the cases opened. We typically have about 160 cases open at any given time. Following post-payment review, an initial letter is sent to the provider identifying the preliminary findings and amount of the potential overpayment. Within ten days of receipt of the letter, the provider may request an informal conference to discuss the findings and/or submit additional documentation for review prior to issuance of a final demand letter. Following an

informal conference and/or a review of additional documentation, a final determination is made. A final demand letter is then issued informing the provider of the final findings and amount of the overpayment, along with the provider's appeal rights. This letter notifies the provider they may submit payment in full to SCDHHS or be invoiced in thirty days. If no appeal is filed within thirty days of receipt of the letter, then the SCDHHS Division of Accounting Operations (DAO) sets up an account receivable for the amount of the overpayment. The provider has the option to contact the DAO to arrange payment. Payment arrangements can include a single payment by check for the full amount, a regular payment schedule, payment by a single adjustment of future claims, or payment by monthly or weekly claim adjustments. If an appeal is filed by the provider, the DAO establishes an account receivable but holds any invoice or other action until the appeal is resolved. If the provider has not submitted payment or made other payment arrangements within ninety days of the receivable being established, DAO issues a claims adjustment to the provider's Medicaid reimbursement for the full amount if the provider is still active and submitting Medicaid claims. If the provider is no longer submitting claims for reimbursement, DAO sends the case to the Office of General Counsel to initiate legal action to recover the funds owed.

-The Division of Audits reviews DHHS contracts with external entities in order to ensure that contract terms are met and only allowable costs are charged.

Entities falling into the following categories must have an annual audit completed by an independent certified public accountant in accordance with generally accepted auditing standards as described:

1) DSN Boards and entities grandfathered in as DSN Boards, that receive financial assistance (program contracts, grants, sub-grants, etc.) from SCDDSN during the state fiscal year ended June 30 – required to obtain an annual financial audit by an independent CPA

2) DSN Boards and entities grandfathered in as DSN Boards that expend $750,000 or more in federal awards – required to obtain an audit in accordance with the Uniform Administration Requirements, Cost Principles, and Audit Requirements for Federal Awards (Medicaid funds received by DSN Boards are not considered federal awards)

3) Organizations receiving sub-grants from DSN Boards and entities grandfathered in as DSN Boards which receive DDSN funds must treat the sub-grants as if they were received directly from DDSN – required to obtain an audit in accordance with one of the two categories listed above

If a DSN Board is recognized as part of county government, then the county audit, if it meets the requirements of the DDSN Audit Policy, is accepted and a separate audit is not required.

DSN Boards and entities grandfathered in as DSN Boards are required to submit a report on applying agreed-upon procedures prepared by a CPA for the state fiscal year ended June 30 or the DSN Board's year end. .

Final inspection and acceptance of the audit documents is the responsibility of DDSN's Internal Audit Division. DSN Boards for which an audit and RoAAP were required must submit a corrective action plan to address problems identified in the audit findings or submit a statement of reasons why no corrective action plan is necessary.

You may refer to DDSN Directive 275-04-DD for more detail regarding policies related to DSN Boards.

Contracted Qualified Service Providers (QPLs) receiving $250,000 or more in financial assistance (program contracts, grants, sub-grants, etc.) from DDSN during the QPL's fiscal year and performing any DDSN Medicaid-billable services AND provide residential habilitation services are required to submit:

1) An audit performed by an independent CPA in accordance with generally-accepted auditing standards and/or the standards of the Public Company Accounting Oversight Board

2) A report on applying agreed-upon procedures (RoAAP) prepared by a CPA for the QPL's year end

QPLs receiving $250,000 or more in financial assistance (program contracts, grants, sub-grants, etc.) from DDSN during the QPL's fiscal year and performing any DDSN Medicaid-billable services which do NOT provide residential habilitation services are required to submit a report on applying agreed-upon procedures (RoAAP) prepared by a CPA for the QPL's year end.

Final inspection and acceptance of the audit documents is the responsibility of the DDSN Internal Audit Division. QPLs are required to submit corrective action plans to address negative findings. Such findings are revisited by the CPA during the next audit cycle. If the subsequent audit shows a reoccurrence of a negative finding, the DDSN Internal Audit Division

takes action as appropriate based on the seriousness of the finding.

You may refer to DDSN Directive 275-06-DD for more detail regarding policies related to QPLs.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. **Methods for Discovery: Financial Accountability 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:
Number of HASCI waiver participants claims that are coded and paid in accordance with policies in the approved waiver. N = the number of HASCI waiver participant claims that paid correctly as determined through record reviews./ D = the total number of claims for HASCI waiver participants 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**	☐ **Annually**	☐ **Stratified**

Specify:		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 Recoupment 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 Source (Select one):
Other
If 'Other' is selected, specify:

DDSN QIO Adjustment Logs

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☑ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☑ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **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 Contractor	☑ **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:
Number of HASCI waiver service rates that remain consistent with approved methodology. N = the number of HASCI service rate changes. / D = the total number of HASCI 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**

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:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible. DDSN's Internal Audit Division 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 in a timely manner.

See Appendix B-QI-a-ii for further information on the sampling methodology.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
DHHS financial policy requires DDSN to void/replace incorrect claims using the web-based system. DDSN reviews and amends its' financial policies and procedures upon review and approval by 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:	☐ **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 HASCI 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 three 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 HASCI 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 region) 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 three other waiver administered by the contractor SCDDSN), SCDHHS is currently 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 has 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 has 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 through 2016 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 will be on site at SCDDSN late summer or early fall to help SCDDSN complete and submit the SFY 2016 cost reports. 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 applies to the following services directly administered by the SCDDSN:
Attendant Care* (DSN Boards and UAP)
Career Preparation
Employment Services
Day Activity
Respite Care (Institutional and Non-Institutional)
Health Education
Peer Guidance
Psychological Counseling
Residential Habilitation
Specialized Medical Equipment and Supplies (manual pricing)
Environmental Modifications (manual pricing)
Private Vehicle Modification (manual pricing)
Private Vehicle Assessment/Consultation (manual pricing)

Waiver Case Management rates (face to face and non-face to face) were constructed based on the governmental provider’s salary and fringe data, estimates of associated direct operational costs, and the 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.

* Attendant Care services provided by a CLTC provider (i.e. private agency) are paid the attendant care rate as

established for the Community Choices waiver.

RN and LPN services (and enhanced RN and LPN services) are paid at the rates established in the State Plan for similar services.

Incontinence supplies for all 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.
Therapy services (occupational, physical, audiology, and speech) are reimbursed to the private providers of these services based on the State Plan methodologies outlined for these services.

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 reassign their right to direct payments to the SCDDSN. Providers billing SCDHHS directly may bill either by use of a CMS 1500 form or by the DHHS's electronic billing system/webtool.

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 form or through the State's electronic billing system/webtool.

-Providers of waiver services are given a service authorization, which reflects the service identified on the Support Plan. This authorization is produced by the Service Coordinator 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 an indication in MMIS that the participant is enrolled in the waiver program.

-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 recipient special program (RSP) in MMIS identifying an individual as a waiver participant.

-SCDHHS Division of Program Integrity conducts post-payment reviews. These reviews sample claims and determine if services have been billed as authorized.

-SCDDSN internal audit division periodically conducts audits of DDSN's billing system to ensure billing is appropriate for the service provided.

If the provider sends a check to reimburse SCDHHS for the inappropriate billings that have been paid, the receivable is posted the way it was paid out. This decreases expenditures in Federal Funds against that particular Federal Grant and nets against current expenditures for reporting purposes.

If we adjust claims moving forward, we are reducing current claims by the inappropriate billing amount, thereby reducing the Federal share.

If a receivable is over one year old, a Journal Entry is made to move the Federal portion of the receivable to an earmarked fund, thereby paying back the Federal portion of that receivable.

Please see Appendix I-1 for the methods the State uses to recoup payment for inappropriate billing.

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*):

- [ ] **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:

DDSN contracts with a financial management services (FMS) entity 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.

-SC Medicaid Providers who have completed the electronic application process will receive an official provider packet of information that includes information on how to assist them with the process of billing Medicaid directly. The following items are several ways SC Medicaid Providers are provided information on the billing process: Medicaid Policy; Medicaid Bulletins; agency e-mail notices/communications; meetings; Free Medicaid Training Workshops; and the Provider Service Center (PSC). Providers may call the PSC at (888) 289-0709, or submit an

e-Inquiry.

Also, SC Medicaid Providers can access these tools @ SCDHHS Home website https://www.scdhhs.gov/ . Once providers access this home page they may click onto the Provider Tab for ALL Provider Information to include Web Based Claim Submission Billing @ https://www.scdhhs.gov/provider .

☐ **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 the listing of services identified in Appendix I, I-2a.

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 payments 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.

DDSN

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 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 waiver participants.

(b) Providers may follow standard enrollment procedures to direct bill their services to DHHS.

(c) Waiver participants are given a choice of providers, regardless of their affiliation with the OHCDS, when their initial plan of care is developed. This same freedom of choice is then given annually thereafter, or more frequently if requested or warranted. Quality assurance reviews performed by DDSN's QIO and DHHS QA staff ensure this is taking place.

(d) DDSN assures that providers wishing to furnish waiver services meet DHHS-approved qualifications as part of their provider enrollment process and/or the state's procurement process. Quality reviews performed by DDSN's QIO ensure providers maintain compliance.

(e) Expectations concerning DDSN's operation and administration of the waiver are delineated through an MOA and a service contract. DDSN assures that contracts with providers meet applicable requirements via an annual quality assurance review of the provider, as well as periodic record reviews.

(f) DDSN requires its DSN Boards to perform annual financial audits.

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

- ◉ **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.

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**
- [x] **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 SCDHHS via an Interdepartmental Transfer (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:

Head and Spinal Cord Injury waiver has only one service, residential habilitation, in which room and board could be included in the service. Continual monitoring and training is provided to assure that room and board costs are excluded. Through the annual audits, financial testing of residential cost is performed by independent CPA firms to assure that room and board costs are excluded from Medicaid payment.

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: Nursing Facility, 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	39557.85	12950.00	52507.85	46884.00	10249.00	57133.00	4625.15
2	40644.41	13211.00	53855.41	48773.00	10526.00	59299.00	5443.59
3	41853.82	13478.00	55331.82	50327.00	10810.00	61137.00	5805.18
4	42919.72	13749.00	56668.72	51976.00	11102.00	63078.00	6409.28
5	43951.14	14026.00	57977.14	53535.00	11401.00	64936.00	6958.86

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: Nursing Facility	Level of Care: ICF/IID
Year 1	1070	1042	28
Year 2	1126	1097	29
Year 3	1185		

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: Nursing Facility	Level of Care: ICF/IID
		1155	30
Year 4	1247	1216	31
Year 5	1312	1279	33

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.

Year 1 - 11.01 months; 335 days
Year 2 - 11.12 months; 338 days
Year 3 - 11.14 months; 339 days
Year 4 - 11.17 months; 340 days
Year 5 - 11.17 months; 340 days

This estimate is built through trending and averaging based on the last five HASCI Waiver 372 Reports (2012 through 2016). Year over year ALOS is increased slightly in recognition of the fact that a greater and greater percentage of enrollees are made up of participants enrolled more than a year ago.

The values above are lower than those submitted in our previous waiver renewal. In 2014, the HASCI Waiver waiting list was eliminated resulting in an increased rate of enrollments. This raised the percentage of participants enrolled for a partial year.

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 for these estimates is as follows:

Number of service users and units/user are estimated through trend analysis of participant and service utilization paid claims data (also used for CMS 372 reporting) mainly from SFY15 through SFY17, projections for services being terminated and/or introduced, and average length of stay. Average per unit cost is based on current service rates with a 2% growth factor per the BLS MCPI for SFY18. The same methodology is used for all services.

The new vehicle and assistive technology consultation service projections are based on prior waiver year utilization, when the consultation services were included as a component part of the vehicle and assistive technology services. The new pest control service projections are based on the historical utilization and cost data for the same services in the SC Community Choices Waiver.

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:

D' is the average of the 2015 372 report, the 2016 372 report and an internal initial 372 report for 2017. DHHS applied a growth factor of 2% per the BLS MCPI for SFY18.

The projections are based on Medicaid expenditures only and are therefore adjusted to exclude any payment of prescription drugs for dual eligibles under the provisions of Part D.

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 relevant comparison population is extremely small. As a result, the yearly per person and overall expenditures for the group vary so widely as to not be a reliable source of data in generating Factor G.

As an alternative, estimates are based on using the unduplicated recipient counts and average lengths of stay utilized in calculating D as well as the most recent SFY18 per diem nursing facility rate loaded in our payment system.

For each waiver year: G = (unduplicated recipients in D x NF per diem rate x ALOS)/unduplicated recipients in D

DHHS applied a growth factor of 3% per the BLS MCPI for SFY15-17.

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:

Again, since comparison group data is not reliable, an alternative approach has been employed for establishing Factor G'.

Like the HASCI Waiver, the SC Vent Waiver serves a population needing specialized care and uses NF LOC. It is reasonable to assume G' costs for the two populations are comparable. The amounts entered in the G' column of this document are the same as those entered in the G' column of the Vent Waiver document. The Vent Waiver renewal was approved by CMS on December 18, 2017. Therefore, the data is current.

A growth factor of 2.7% was applied to Waiver Years 2 through 5. As stated in Appendix J-2c of the Vent Waiver, this value represents an average of the MCPI from September 2013 through September 2017.

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	
Attendant Care/Personal Assistance Services	
Career Preparation Services	
Day Activity	
Residential Habilitation	
Respite Care Services	
Waiver Case Management (WCM)	
Incontinence Supplies	
Occupational Therapy	
Physical Therapy	
Speech and Hearing Services	
Behavioral Support Services	
Employment Services	
Environmental Modifications	
Health Education for Participant-Directed Care	
Medicaid Waiver Nursing	
Peer Guidance for Participant-Directed Care	
Personal Emergency Response Systems	
Pest Control Bed Bugs	
Pest Control Treatment	
Private Vehicle Assessment/Consultation	
Private Vehicle Modifications	
Psychological Services	
Supplies, Equipment and Assistive Technology Assessment/Consultation	
Supplies, Equipment and Assistive Technology	

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
Attendant Care/Personal Assistance Services Total:						**28301950.85**
Agency	Hour	749	1685.00	17.00	**21455105.00**	
Self Directed	Hour	268	1685.00	14.13	**6380825.40**	
DSN Board	Hour	21	1685.00	13.17	**466020.45**	
Career Preparation Services Total:						**85551.84**
Career Preparation Services	1/2 Day	11	396.00	19.64	**85551.84**	
Day Activity Total:						**85551.84**
Day Activity	1/2 Day	11	396.00	19.64	**85551.84**	
Residential Habilitation Total:						**4337434.20**
Daily Residential	Day	54	330.00	230.50	**4107510.00**	
Hourly Residential	Hour	11	330.00	63.34	**229924.20**	
Respite Care Services Total:						**785553.78**
Institutional ICF/IID Based	Day	11	33.00	280.15	**101694.45**	
Institutional NF/Hospital Based	Day	11	33.00	120.00	**43560.00**	
Non Institutional Based	Hour	128	363.00	12.69	**589628.16**	
CRCF Based	Hour	11	363.00	12.69	**50671.17**	
Waiver Case Management (WCM) Total:						**1984422.00**
WCM Face to Face	15 Min	1070	33.00	25.20	**889812.00**	
WCM Non Face to Face	15 Min	1070	66.00	15.50	**1094610.00**	
					GRAND TOTAL:	**42326898.69**
					Total Estimated Unduplicated Participants:	**1070**
					Factor D (Divide total by number of participants):	**39557.85**
					Average Length of Stay on the Waiver:	335

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Incontinence Supplies Total:						**235400.00**
Incontinence Supplies	Month	428	11.00	50.00	**235400.00**	
Occupational Therapy Total:						**26136.00**
Occupational Therapy	15 Min	11	264.00	9.00	**26136.00**	
Physical Therapy Total:						**17424.00**
Physical Therapy	15 Min	11	176.00	9.00	**17424.00**	
Speech and Hearing Services Total:						**18072.00**
Speech Language Pathologist	Assessment	4	1.00	54.00	**216.00**	
Speech Therapist	Assessment	4	1.00	54.00	**216.00**	
Audiologist	Assessment	4	1.00	54.00	**216.00**	
Speech Hearing and Language Therapy	15 Min	11	176.00	9.00	**17424.00**	
Behavioral Support Services Total:						**29040.00**
Behavioral Support Services	30 Min	11	88.00	30.00	**29040.00**	
Employment Services Total:						**18877.32**
Employment Services	Hour	21	44.00	20.43	**18877.32**	
Environmental Modifications Total:						**1032000.00**
Environmental Modifications	Item	86	1.00	12000.00	**1032000.00**	
Health Education for Participant-Directed Care Total:						**2420.00**
Health Education for Consumer Directed Care	Hour	11	11.00	20.00	**2420.00**	
Medicaid Waiver Nursing Total:						**1989400.16**
Licensed Practical Nurse	Hour	86	705.00	23.76	**1440568.80**	
Registered Nurse	Hour	43	407.00	31.36	**548831.36**	
Peer Guidance for Participant-Directed Care Total:						**2420.00**
Peer Guidance for Participant-Directed Care	Hour	11	11.00	20.00	**2420.00**	
Personal Emergency Response Systems Total:						**90060.00**
Recurring Maintenance					**88440.00**	

GRAND TOTAL:	**42326898.69**
Total Estimated Unduplicated Participants:	**1070**
Factor D (Divide total by number of participants):	**39557.85**
Average Length of Stay on the Waiver:	335

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	Month	268	11.00	30.00		
Initial Installation	Item	54	1.00	30.00	**1620.00**	
Pest Control Bed Bugs Total:						**32000.00**
Pest Control Bed Bugs	1 x Year	32	1.00	1000.00	**32000.00**	
Pest Control Treatment Total:						**104395.50**
Pest Control Treatment	6 x Year	407	6.00	42.75	**104395.50**	
Private Vehicle Assessment/Consultation Total:						**25800.00**
Private Vehicle Assessment/Consultation	Assessment	43	1.00	600.00	**25800.00**	
Private Vehicle Modifications Total:						**774000.00**
Private Vehicle Modifications	Item	43	1.00	18000.00	**774000.00**	
Psychological Services Total:						**44915.20**
Drug/Alcohol Counseling	Hour	11	44.00	38.80	**18779.20**	
Counseling/Mental Health Services	30 Min	11	88.00	27.00	**26136.00**	
Supplies, Equipment and Assistive Technology Assessment/Consultation Total:						**112500.00**
Supplies, Equipment and Assistive Technology Assessment/Consultation	Assessment	375	1.00	300.00	**112500.00**	
Supplies, Equipment and Assistive Technology Total:						**2191574.00**
Supplies, Equipment and Assistive Technology	Item	749	11.00	266.00	**2191574.00**	
			GRAND TOTAL:			**42326898.69**
			Total Estimated Unduplicated Participants:			**1070**
			Factor D (Divide total by number of participants):			**39557.85**
			Average Length of Stay on the Waiver:			335

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
Attendant Care/Personal Assistance Services Total:						**30698003.86**
Agency	Hour	788	1702.00	17.34	**23255991.84**	
Self Directed	Hour	282	1702.00	14.41	**6916281.24**	
DSN Board	Hour	23	1702.00	13.43	**525730.78**	
Career Preparation Services Total:						**88132.00**
Career Preparation Services	1/2 Day	11	400.00	20.03	**88132.00**	
Day Activity Total:						**88132.00**
Day Activity	1/2 Day	11	400.00	20.03	**88132.00**	
Residential Habilitation Total:						**4634874.58**
Daily Residential	Day	56	334.00	235.11	**4397497.44**	
Hourly Residential	Hour	11	334.00	64.61	**237377.14**	
Respite Care Services Total:						**841509.53**
Institutional ICF/IID Based	Day	11	33.00	285.75	**103727.25**	
Institutional NF/Hospital Based	Day	11	33.00	122.40	**44431.20**	
Non Institutional Based	Hour	135	367.00	12.94	**641112.30**	
CRCF Based	Hour	11	367.00	12.94	**52238.78**	
Waiver Case Management (WCM) Total:						**2147698.62**
WCM Face to Face	15 Min	1126	33.00	25.70	**954960.60**	
WCM Non Face to Face	15 Min	1126	67.00	15.81	**1192738.02**	
Incontinence Supplies Total:						**252450.00**
Incontinence Supplies	Month	450	11.00	51.00	**252450.00**	
Occupational Therapy Total:						**26961.66**
Occupational Therapy	15 min	11	267.00	9.18	**26961.66**	
Physical Therapy Total:						**17974.44**
Physical Therapy	15 min	11	178.00	9.18	**17974.44**	

GRAND TOTAL:	**45765601.59**
Total Estimated Unduplicated Participants:	**1126**
Factor D (Divide total by number of participants):	**40644.41**
Average Length of Stay on the Waiver:	338

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Speech and Hearing Services Total:						**18635.40**
Speech Language Pathologist	Assessment	4	1.00	55.08	**220.32**	
Speech Therapist	Assessment	4	1.00	55.08	**220.32**	
Audiologist	Assessment	4	1.00	55.08	**220.32**	
Speech Hearing and Language Therapy	15 Min	11	178.00	9.18	**17974.44**	
Behavioral Support Services Total:						**57191.40**
Behavioral Support Services	30 min	21	89.00	30.60	**57191.40**	
Employment Services Total:						**21090.08**
Employment Services	Hour	23	44.00	20.84	**21090.08**	
Environmental Modifications Total:						**1101600.00**
Environmental Modifications	Item	90	1.00	12240.00	**1101600.00**	
Health Education for Participant-Directed Care Total:						**4712.40**
Health Education for Consumer Directed Care	Hour	21	11.00	20.40	**4712.40**	
Medicaid Waiver Nursing Total:						**2146393.80**
Licensed Practical Nurse	Hour	90	712.00	24.24	**1553299.20**	
Registered Nurse	Hour	45	412.00	31.99	**593094.60**	
Peer Guidance for Participant-Directed Care Total:						**4712.40**
Peer Guidance for Participant-Directed Care	Hour	21	11.00	20.40	**4712.40**	
Personal Emergency Response Systems Total:						**96634.80**
Recurring Maintenance	Month	282	11.00	30.60	**94921.20**	
Initial Installation	Item	56	1.00	30.60	**1713.60**	
Pest Control Bed Bugs Total:						**34680.00**
Pest Control Bed Bugs	1 x Year	34	1.00	1020.00	**34680.00**	
Pest Control Treatment Total:						**111990.48**
Pest Control Treatment	6 x Year	428	6.00	43.61	**111990.48**	

GRAND TOTAL:	**45765601.59**
Total Estimated Unduplicated Participants:	**1126**
Factor D (Divide total by number of participants):	**40644.41**
Average Length of Stay on the Waiver:	338

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Private Vehicle Assessment/Consultation Total:						**27540.00**
Private Vehicle Assessment/Consultation	Assessment	45	1.00	612.00	**27540.00**	
Private Vehicle Modifications Total:						**826200.00**
Private Vehicle Modifications	Item	45	1.00	18360.00	**826200.00**	
Psychological Services Total:						**46118.38**
Drug/Alcohol Counseling	Per Hour	11	44.00	39.58	**19156.72**	
Counseling/Mental Health Services	Per Hour	11	89.00	27.54	**26961.66**	
Supplies, Equipment and Assistive Technology Assessment/Consultation Total:						**120564.00**
Supplies, Equipment and Assistive Technology Assessment/Consultation	Assessment	394	1.00	306.00	**120564.00**	
Supplies, Equipment and Assistive Technology Total:						**2351801.76**
Supplies, Equipment and Assistive Technology	Item	788	11.00	271.32	**2351801.76**	
				GRAND TOTAL:		**45765601.59**
				Total Estimated Unduplicated Participants:		**1126**
				Factor D (Divide total by number of participants):		**40644.41**
				Average Length of Stay on the Waiver:		338

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
Attendant Care/Personal Assistance Services Total:						**33013403.50**
Agency	Hour	830	1705.00	17.69	**25034003.50**	
Self Directed	Hour	296	1705.00	14.70	**7418796.00**	
DSN Board	Hour	24	1705.00	13.70	**560604.00**	
Career Preparation Services Total:						**262157.76**
Career Preparation Services	1/2 Day	32	401.00	20.43	**262157.76**	
Day Activity Total:						**262157.76**

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Activity	1/2 Day	32	401.00	20.43	262157.76	
Residential Habilitation Total:						4989823.06
Daily Residential	Day	59	334.00	239.81	4725695.86	
Hourly Residential	Hour	12	334.00	65.90	264127.20	
Respite Care Services Total:						912933.12
Institutional ICF/IID Based	Day	12	33.00	291.47	115422.12	
Institutional NF/Hospital Based	Day	12	33.00	124.85	49440.60	
Non Institutional Based	Hour	142	368.00	13.20	689779.20	
CRCF Based	Hour	12	368.00	13.20	58291.20	
Waiver Case Management (WCM) Total:						2305583.40
WCM Face to Face	15 Min	1185	33.00	26.21	1024942.05	
WCM Non Face to Face	15 Min	1185	67.00	16.13	1280641.35	
Incontinence Supplies Total:						282676.68
Incontinence Supplies	Month	494	11.00	52.02	282676.68	
Occupational Therapy Total:						29989.44
Occupational Therapy	15 Min	12	267.00	9.36	29989.44	
Physical Therapy Total:						19992.96
Physical Therapy	15 Min	12	178.00	9.36	19992.96	
Speech and Hearing Services Total:						20667.12
Speech Language Pathologist	Assessment	4	1.00	56.18	224.72	
Speech Therapist	Assessment	4	1.00	56.18	224.72	
Audiologist	Assessment	4	1.00	56.18	224.72	
Speech Hearing and Language Therapy	15 Min	12	178.00	9.36	19992.96	
Behavioral Support Services Total:						88886.08
Behavioral Support Services	30 Min	32	89.00	31.21	88886.08	
Employment Services Total:						22960.80
Employment Services	Hour	24	45.00	21.26	22960.80	

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Environmental Modifications Total:						**1186056.00**
Environmental Modifications	Item	95	1.00	12484.80	**1186056.00**	
Health Education for Participant-Directed Care Total:						**7325.12**
Health Education for Consumer Directed Care	Hour	32	11.00	20.81	**7325.12**	
Medicaid Waiver Nursing Total:						**2306256.52**